

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07554

07531

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS Lot #15 - Trailer Court	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK J. ANGLIN		4. DATE OF DEATH Month Day Year 6 13 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8 Feb 1926
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY State Hospital	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Grady Anglin		14. MOTHER'S MAIDEN NAME MAY AUSTIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 244301105	
17. INFORMANT JULIAN S. BREWER		Address 5420 CARVILLE AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 6-14-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/16/1967	23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTO Md.
24. FUNERAL DIRECTOR E. S. MacNabb 301 Frederick Rd Balto 28 Md.		25a. REC'D BY REGISTRAR JUN 19 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

100

REPORT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07555 CERTIFICATE OF DEATH 07532

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE CALIFORNIA b. COUNTY SAN DIEGO		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SAN DIEGO	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US NAVAL HOSPITAL, ANNAPOLIS, MD.			d. STREET ADDRESS 1528 MONITOR ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle NMN Last ANTONIAK			4. DATE OF DEATH Month JUNE Day 3 Year 19 67		
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 DEC 1911	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAPTAIN		10b. KIND OF BUSINESS OR INDUSTRY US NAVY RETIRED		11. BIRTHPLACE (County & State, or foreign country) AUBURN, NEW YORK	
13. FATHER'S NAME JOHN ANTONIAK			14. MOTHER'S MAIDEN NAME HELEN ZCALICZ		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1934-1954 571488329		17. INFORMANT MARGUARITA ELLEN ANTONIAK (WIFE) Address SAME AS DEC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) unknown					INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) unknown			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) DOA	
20f. (City or town) SAN DIEGO		20g. (County) CA		20h. (State) CA	
21. I certify that (I) (this hospital) attended the deceased from DOA , 19____, to____, 19____, that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9:15 from the causes and on the date stated above.					
22a. SIGNATURE William Ross Kennedy			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3 JUNE 67
22c. PHYSICIAN'S NAME (Type) WILLIAM ROSS KENNEDY, LT MC USNR			22d. ADDRESS USNH ANNAPOLIS, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-17-67		23c. NAME OF CEMETERY OR CREMATORY Holy Cross	
23d. LOCATION (City, town or county) San Diego		23e. (State) Calif.		23f. REGISTRAR'S SIGNATURE John M. Paylor + Sons	
24. FUNERAL DIRECTOR John M. Paylor + Sons		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR JUN 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

1955

RECEIVED

RECEIVED

US NAVAL HOSPITAL, ANNAPOLIS, MD.

CHIEF

MD

PHYSICIAN

1958 HOSPITAL RECORD

25 DEC 1951

US NAVY RETIRED

PHYSICIAN, NEW YORK

JOHN ANTHONY

JOHN ANTHONY

1951-1954

20148352

NAVY HOSPITAL, ANNAPOLIS (MD) 1951-1954

1951

US NAVY, ANNAPOLIS, MD.

WILLIAM ROSS KENNEDY, JR. MD. USN

John M. Pugh
First Lt
US Navy

San Diego

Calif.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07533

07556

CERTIFICATE OF DEATH

07533

1. PLACE OF DEATH a. COUNTY AA Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 10 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 202 Poplar Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle W Last Armiger Sr.				4. DATE OF DEATH Month June Day 4 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH 1-30-1878	
9. AGE (In years last birthday) 89 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/> &O Railroad		11. BIRTHPLACE (County & State, or foreign country) Prince George Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Thomas Armiger			
14. MOTHER'S MAIDEN NAME Georgianna Duckett				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-54-9776		17. INFORMANT Address Mr. Albert W. Armiger (son) Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm DUE TO Aortic Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalized (c) Arteriosclerosis generalized							INTERVAL BETWEEN ONSET AND DEATH Hours 10-12 hrs years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-4-1967 , to 6-4-1967 , that (I) (we) last saw the deceased alive on 6-4-1967 , and that death occurred at 8 P. M, from causes and on the date stated above.							
22a. SIGNATURE Robert J. Marley				22b. DATE SIGNED 6-5-67		22c. PHYSICIAN'S NAME (Type) Robert J. Marley	
22d. ADDRESS Bladensburg, Maryland				22e. REC'D BY REGISTRAR Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR Singleton Funeral Home				25a. REC'D BY REGISTRAR June 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1350

UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07557

CERTIFICATE OF DEATH

07534 07534

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>6 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>213 S. Paca Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Howard</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9/26/02</u>		9. AGE (In years lost birthday) yrs. <u>64</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed CAB DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles L. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Ashton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>N/A</u>		16. SOCIAL SECURITY NO. <u>220-05-7283</u>		17. INFORMANT Address <u>Mrs Helen A. Aschemeier 9220 Satyr Hill Rd</u> <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of floor of the mouth</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>		
21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>67</u> , to <u>6/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>67</u> , and that death occurred at <u>7:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>L. Benedict</u>				22b. DATE SIGNED <u>6/19/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>	
22d. ADDRESS <u>Crownsville State Hospital</u>		22e. ADDRESS <u></u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>		
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>				25a. RECD BY REGISTRAR <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1953

RECEIVED

1953

RECEIVED

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07558

Item #2d Film #G389 6/12/67 pc

Items #11,12,13 & 14 Film #G359 6/20/67 pc

CERTIFICATE OF DEATH

07535

1. PLACE OF DEATH a. COUNTY <u>Glen Burnie</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Maryland</u>				c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Laurel Convalescent Center</u>				d. STREET ADDRESS <u>5311 Ballman Ave.</u>					
3. NAME OF DECEASED (Type or print) <u>LEVI F. BARNES</u>				4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/16/1887</u>			
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>5/18</u> , 19 <u>67</u> , to <u>6/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/18</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes on and on the date stated above.									
22a. SIGNATURE <u>Wayne B. Tate</u>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Wayne B. Tate, M.D.</u>				22d. ADDRESS <u>108 Central Ave. Glen Burnie</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial June, 1967</u>		<u>Providence</u>		<u>Canoll Co</u>					
24. FUNERAL DIRECTOR <u>Paul E. Chomowicz</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 8 1967</u>					
ADDRESS <u>3615 Chestnut Ave</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

3525

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07537

1. PLACE OF DEATH a. COUNTY <u>AACO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Anne Arundel - Gen.</u>		d. STREET ADDRESS <u>120 Darrington St. S.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANITA L. Biggers</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 1, 1941</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer S Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Daisy L Ward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Daisy L. Jackson</u>		Address <u>White Sulphur 55 Barten Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9294</u> DUE TO <u>Choking</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Shaken</u> DUE TO <u>Shaken</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>While running Sandy Creek</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> p.m. <u>6/27/1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>Long Point</u>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State) <u>AAco MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Jackson</u>		22. DATE SIGNED <u>6/27/67</u>	
EXAMINER'S NAME (Type) <u>E. L. Jackson</u>		M.D. <u>E. L. Jackson</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>6-29-67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <u>Takoth W. VA</u>	
24. FUNERAL DIRECTOR <u>A.S. Washington & Sons</u>		ADDRESS <u>4925 Denne Ave</u>	
25a. REC'D BY REGISTRAR <u>DATE 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07538

1. PLACE OF DEATH a. COUNTY <u>A.A. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington - DC</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - ANNIE MONDEL - Hospital.</u>				d. STREET ADDRESS <u>120 - Parlington St. S.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>M.</u> Last <u>Biggers</u>				4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-37</u>	9. AGE (In years lost birthday) yrs. <u>29</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Firm</u>		11. BIRTHPLACE (State or foreign country) <u>Takott W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Howard Biggers</u>				14. MOTHER'S MAIDEN NAME <u>Anita Luster</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>James Biggers Charleston W. VA</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>drowning</u> DUE TO <u>9297</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shaded</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u>Swim in Lake - While Drowning</u>				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Long Pond</u>		20f. (City or town) (County) (State) <u>A.A. CO. MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Lowbanc</u>			M.D.			22. DATE SIGNED <u>6-26-67</u>	
EXAMINER'S NAME (Type) <u>E. Lowbanc</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-29-67</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <u>Takott W. VA.</u>	
24. FUNERAL DIRECTOR <u>H.S. Washington + Son 4925 Denne Ave NE</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PD-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07561

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07539

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. George & Meade</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tessup</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kimbrough Army Hospital</u>			d. STREET ADDRESS <u>Box 172</u>		
3. NAME OF DECEASED (Type or print) First <u>Crescentia</u> Middle <u>M.</u> Last <u>Blob</u>			4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 16, 1893</u>	9. AGE (In years lost birthday) yrs. <u>74</u>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>John Philipps</u>			14. MOTHER'S MAIDEN NAME <u>Mary Prosser</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-36-4106 D</u>		
17. INFORMANT <u>Mr. Max F. Blob</u>			Address <u>5600 Ashbourne Rd.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis Generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. Hubbard</u> EXAMINER'S NAME (Type)		M.D. <u>E. Hubbard</u>		22. DATE SIGNED <u>6-5-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/9/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk. Cemet.</u>		23d. LOCATION (City or Town) (County) (State) <u>Dorsey, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. F. Tubman & Sons</u>			Address <u>Baltimore, Md.</u>		
25a. REC'D BY REGISTRAR DATE <u>JUN 7 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07562

CERTIFICATE OF DEATH

07540

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Thomas Point	
3. NAME OF DECEASED (Type or print) First Ellen Middle Frances Last BOETTCHER		4. DATE OF DEATH Month June Day 17 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1926
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPT. REG. CLERK		10b. KIND OF BUSINESS OR INDUSTRY H.A. Co.	
11. BIRTHPLACE (County & State, or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME F. THEODORE BOETTCHER		14. MOTHER'S MAIDEN NAME BELLAH JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. WILEY L. FOWLER		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Spontaneous fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary thrombosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 2 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 17, 1967 , to June 17, 1967 , that (I) (we) last saw the deceased alive on June 17, 1967 , and that death occurred at 5:55 a.m. from causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck M.D.		22b. DATE SIGNED 6/17/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-20-67	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.	
24. FUNERAL DIRECTOR John M. & Sons		25a. REC'D BY REGISTRAR JUN 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

72563

CERTIFICATE OF DEATH

Ann Arbor, Michigan
Ann Arbor, Michigan

Ann Arbor, Michigan

Ann Arbor, Michigan

Ann Arbor, Michigan

Ann Arbor, Michigan

Ann Arbor, Michigan

Ann Arbor, Michigan

Mrs. Wiley L. Fox

[Faint, mostly illegible text and signatures follow, including what appears to be a date "June 17, 1917" and a signature "Wm. L. Fox"]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07563					07541				
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Millersville			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Manor Nursing Home					d. STREET ADDRESS 105 Solomons Island Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle ERVIN Last BOSTON					4. DATE OF DEATH Month June Day 17 Year 1967				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 30-1885		9. AGE (In years last birthday) 82 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - retired				10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (County & State, or foreign country) A.A.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Boston					14. MOTHER'S MAIDEN NAME Louise Sargent				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-34-4688 A		17. INFORMANT Annapolis, Md. Helen W. Boston-105 Solomons Island Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Causes of Death c 177X DUE TO Widow's friend me husband Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/11 , 19 67 to 6/17 , 19 67 that (I) (we) last saw the deceased alive on 6/14 , 19 67 , and that death occurred at 2 P.M. from the causes and on the date stated above.									22b. DATE SIGNED 6/19/67
22a. SIGNATURE MAURICE F. KLAUWANS				22c. PHYSICIAN'S NAME (Type) MAURICE F. KLAUWANS		22d. ADDRESS 3150 SOUTH GATE AVE		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF June 20-67		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) (State) Annapolis, Md.		
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.					25a. REC'D BY REGISTRAR DATE JUN 22 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
07564 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						07542 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Annapolis b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis						c. LENGTH OF STAY IN 1b Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Naval Hospital, Annapolis, Md.						e. STREET ADDRESS 620 Americana Drive					
3. NAME OF DECEASED (Type or print) WARREN EDWIN BRADBURY						4. DATE OF DEATH June 8 1967					
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 August 1889		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor				10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (County & State, or foreign country) Neillsville, Wisconsin Clark County			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Lewis Edwin Bradbury						14. MOTHER'S MAIDEN NAME Minnie Della Warren					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1920-1938				16. SOCIAL SECURITY NO. 1920-1938		17. INFORMANT Daughter Address 444 DC St., Mary Elizabeth Groseclose, 209 St., Anna., Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gram neg urinary tract infection DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fractured Left Femur											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 P. to 19 , that (I) (we) last saw the deceased alive on 8 June 1967 , and that death occurred at 1825 M, from the causes and on the date stated above.											
22a. SIGNATURE Roger M. Smith						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-9-67			
22c. PHYSICIAN'S NAME (Type) ROGER SMITH						22d. ADDRESS U.S.N. Hospt, ANNAPOLIS, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-12-67		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		23d. LOCATION (City, town or county) (State) Arlington Va.					
24. FUNERAL DIRECTOR John M. Taylor & Sons, Duke of Gloucester ST. Annapolis, Md.						25a. REC'D BY REGISTRAR HUN 12 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION

155

155

Annapolis

Annapolis

500 American Drive

Local Hospital, Annapolis, Md.

James

OK 2007

EDWIN

WARREN

23 August 1967

1967

Walls, The, Wisconsin
Clark County

Medicine

Doctor

Winnie Dolis Carter

Lois Edwin Broderick

Daughter

Mar. Elizabeth Grossman, 20 St. Anne, Md.



1967

8 June

John M. Taylor & Sons, Inc. of Gloucester St.
Annapolis, Md.
1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
07563 CERTIFICATE OF DEATH 07543										
1. PLACE OF DEATH a. COUNTY <u>Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>30-4</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>N. Arundel Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>1353 Weldon Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Oda</u> Middle <u>Rebecca</u> Last <u>Brittingham</u>					4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1896</u>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Heubeck</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Demory</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>612 03 0050</u>		17. INFORMANT <u>John Weis</u>		Address <u>627 New Jersey Ave. 21061</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA - KIDNEY FAILURE</u> 1530 DUE TO <u>GENERALIZED CARCINOMA</u> (b) <u>CARCINOMA OF Cecum, no RESECTABLE</u> DUE TO <u>16 years</u> (c) <u>16 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 28, 1967</u> to <u>June 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Enrique Moszkowski</u>					22b. OATE SIGNED <u>June 18, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>Enrique Moszkowski</u>					22d. ADDRESS <u>1111 Park Ave.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>June 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				
24. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>					ADDRESS <u>3631 Falls Rd.</u>		25a. REC'D BY REGISTRAR <u>JUN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 07566 CERTIFICATE OF DEATH 07544									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11 Randell Court</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>77 College Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Henrietta Bates Brooke</u>			4. DATE OF DEATH <u>6 - 8 19 67</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-29-1878</u>		9. AGE (in years last birthday) <u>89</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Elliott Bates</u>					14. MOTHER'S MAIDEN NAME <u>Caroline Eliza McCorkle</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- - -</u>			16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Walter E. Joyce; 1625 "K" St. N.W.</u> Address <u>Wash. D.C.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Labor</u> <u>4200</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>64</u> , to <u>8 pm</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8 June 19 67</u> , and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>W. T. Stephens</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8 June 1967</u>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>6-9-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Md.</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>					ADDRESS <u>5130 Wisc. Ave. N.W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE		
					DATE <u>JUN 12 1967</u>				

6050

[Faint handwritten text, likely bleed-through from the reverse side.]

Wm. H. Stephens
Oct 10 1861
1
8 June 1861

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

<div> <div>1</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div>07545</div> </div>															
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Glen Burnee</i> c. LENGTH OF STAY IN 1b <i>3 wks 3 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Boys' Home 7355 fcn Blvd.</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hawwood</i> d. STREET ADDRESS <i>Box 107</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>CHARLES HENRY Brown</i> First Middle Last						4. DATE OF DEATH Month <i>6</i> Day <i>11</i> Year <i>19 67</i>									
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>NEGRO</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/11/1914</i>		9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>11</i>		IF UNDER 24 HRS. Hours <i>19</i> Min. <i>67</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Helper</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>						11. BIRTHPLACE (Country & State, or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. America</i>	
13. FATHER'S NAME <i>BENN E H Brown</i>						14. MOTHER'S MAIDEN NAME <i>Mrs. Brown</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes give war or dates of service)</i>						16. SOCIAL SECURITY NO. <i>218-36-4673</i>						17. INFORMANT <i>Helen Wilson West River MD</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>myocardial infarction</i> (b) <i>Abdominal Carcinomatosis</i> DUE TO <i>Adrenal Carcinomatosis</i> (c) <i>Adrenal Carcinomatosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <i>Sec. hours</i> <i>Sec. months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 18, 1967</i> to <i>June 11, 1967</i> that (I) (we) last saw the deceased alive on <i>June 8, 1967</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.															
22a. SIGNATURE <i>Richard H. Hunt</i>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>June 11, 1967</i>		22c. PHYSICIAN'S NAME (Type) <i>Richard H. Hunt</i>					
22d. ADDRESS <i>100 Cherry Lane, Glen Burnee, Md</i>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>6-15-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cherry Memorial</i>				23d. LOCATION (City, town or county) <i>Chesapeake Md</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese II</i>						ADDRESS <i>108 W WASH ST. ANN</i>		25a. REC'D BY REGISTRAR <i>JUN 14 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION

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STATE OF TEXAS

CERTIFICATE OF MARRIAGE

IN THE COUNTY OF DALLAS

STATE OF TEXAS

BEFORE ME, the undersigned authority, on this day personally appeared

and acknowledged to me that they were the lawful

husband and wife of each other, and that they executed the foregoing

instrument for the purposes and consideration therein expressed.

Given under my hand and seal of office this day of

19

at the City of

State of Texas.

My commission expires this day of

19

Notary Public in and for the State of Texas.

My commission expires this day of

19

Notary Public in and for the State of Texas.

My commission expires this day of

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Notary Public in and for the State of Texas.

My commission expires this day of

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Notary Public in and for the State of Texas.

My commission expires this day of

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Notary Public in and for the State of Texas.

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My commission expires this day of

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Notary Public in and for the State of Texas.

My commission expires this day of

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Notary Public in and for the State of Texas.

My commission expires this day of

19

Notary Public in and for the State of Texas.

My commission expires this day of

19

Notary Public in and for the State of Texas.

My commission expires this day of

19

Notary Public in and for the State of Texas.

My commission expires this day of

19

Notary Public in and for the State of Texas.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07568

07546

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>3627 Robert Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Browning</u> Last <u>Browning</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-07</u> <u>7/13/37</u>		9. AGE (In years last birthday) <u>50-60</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u> <u>William J. Browning Sr.</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u> <u>Bessie Bange</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septecemia</u> <u>609X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>urinary tract infection</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Mentally defective</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>67</u> , to <u>6/21</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6/21</u> , 19 <u>67</u> , and that death occurred at <u>5:25M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>				22d. ADDRESS <u>Crownsville State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John C. Miller Inc-6415 Belair Rd.-21206</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

2325

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07569 CERTIFICATE OF DEATH 07547

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY PITTSBURGH c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PITTSBURGH d. STREET ADDRESS 346 BOWER HILL, PITTSBURGH, PA. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JAMES Middle COVODE Last CAMPBELL			4. DATE OF DEATH Month June Day 7 Year 19 67		
5. SEX MALE		6. COLOR OR RACE CAUC.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 30 MARCH 1945		9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MIDN 67			10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		
11. BIRTHPLACE (County & State, or foreign country) PITTSBURGH, PA.			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME DR. JAMES C. CAMPBELL			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1963 - 1967		17. INFORMANT U.S. Navy Records, Naval Academy, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple injuries 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) auto accident DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 0135A M, from the causes and on the date stated above.					
22a. SIGNATURE Ronald W. Smith			22b. DATE SIGNED June 67		
22c. PHYSICIAN'S NAME (Type) R. W. SMITH, LCDR MC USN			22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUN. 10, 1967		23c. NAME OF CEMETERY OR CREMATORY ROBINSON RUN CEMETERY,	
23d. LOCATION (City, town or county) McDONALD, PENNSYLVANIA		(State)			
24. FUNERAL DIRECTOR Laurel Funeral Home, Laurel, MD.			25a. REC'D BY REGISTRAR Charles Judge		
25b. REGISTRAR'S SIGNATURE Charles Judge			DATE JUN 15 1967		

MEDICAL CERTIFICATION

07560

THE CONDUCT

19013

U.S. MARINE HOSPITAL, MARINE CORPS, MD.

THE BOWEN HILL, PITTSBURGH, PA.

PITTSBURGH, PA.

PITTSBURGH, PA.

JAMES

BRIDGE

CAMPBELL

James

CAMP

3 MARCH 1901

PITTSBURGH, PA.

BRIDGE

U.S. MARINE HOSPITAL, MARINE CORPS, MD.

U.S. MARINE HOSPITAL, MARINE CORPS, MD.

U.S. MARINE HOSPITAL, MARINE CORPS, MD.

U.S. MARINE HOSPITAL, MARINE CORPS, MD.

LAUREL FUNERAL HOME, LAUREL, MD.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07570

07548

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (copy) and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AA CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRHAVEN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRHAVEN</u>	
c. LENGTH OF STAY IN 1b <u>ANNAPOLIS</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - ANNE ARUNDEL - GENERAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Carson Campbell</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/26/42</u>
9. AGE (In years lost birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William C. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Ruth V. Shubert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-44-6656</u>	
17. INFORMANT <u>William C. Campbell</u>		Address <u>Prince Frederick, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Trauma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dead on Collision</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4</u> p.m. <u>6-10</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>AA CO MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>6-10-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, or other disposal (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>June 13, 1967</u>	<u>Friendship Ch. Cem</u>	<u>Friendship A.D. Md</u>
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR
<u>Butchins Funeral Home Owings, Md</u>			<u>JUN 14 1967</u>
25b. REGISTRAR'S SIGNATURE			
<u>Charles Judge</u>			

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There are no other

to be found

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07571

07549

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) In Chesapeake Bay				c. LENGTH OF STAY IN 1b 3 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 204 Marie Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HARRY KEITH CARROLL				4. DATE OF DEATH Month Day Year June 18 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1926	9. AGE (In years lost birthday) 40 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer, Maryland State Police				10b. KIND OF BUSINESS OR INDUSTRY Police Officer		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank L. Carroll				14. MOTHER'S MAIDEN NAME Flourance J. Carroll			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mr. Francis W. Carroll, 62 Pitters Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject jumped into water to rescue brother			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 7 6/17 19 67				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) water	
20f. (City or town) (County) (State) Glen Burnie, Anne Arundel, Md							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF June 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Parkville Cemetery, Parkville, Baltimore, Md.	
24. FUNERAL DIRECTOR Frank H. Newell, Parkville, Md.				25. REC'D BY REGISTRAR JUN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
07572		CERTIFICATE OF DEATH	
07550			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) N. Arundel Hosp.		d. STREET ADDRESS #2 Pershing Avenue, S/W	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DELLA MAE CASWELL		4. DATE OF DEATH Month June Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1907
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Williamsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH HARPER		14. MOTHER'S MAIDEN NAME DOLLIE VAUGHN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. XXXXXXXXXX	
17. INFORMANT Mr. Charles M. Caswell (husband)		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCTION DUE TO (b) CORONARY ARTERY DISEASE DUE TO (c) 7 years		INTERVAL BETWEEN ONSET AND DEATH NONE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS (17 years) (2) OBESITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOVEMBER, 1950 , to June 16, 1967 , that (I) (we) last saw the deceased alive on MAY 27, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Melvin N. Borden		22b. DATE SIGNED June 17, 1967	
22c. PHYSICIAN'S NAME (Type) Melvin N. BORDEN		22d. ADDRESS BALTIMORE MD 21229 5000 BALTIMORE NATIONAL PIKE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 20/67	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. REC'D BY REGISTRAR JUN 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

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RECEIVED OF DEPT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07573

Item #7 Film #G392 8/30/67

CERTIFICATE OF DEATH

07551

Items #5 & 6 Film #0390 7/13/67

1. PLACE OF DEATH a. COUNTY <u>Md</u> <u>AA Co</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA Co</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRISTOL</u>				c. LENGTH OF STAY IN IL <u>LIFE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <u>BRISTOL, Md</u>			
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>(NMI)</u> Last <u>Chaney</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 4, 1916</u>	
9. AGE (in years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ROAD</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>BRISTOL Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOSEPH CHANEY JR</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HALL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>275-18-3487</u>			
17. INFORMANT <u>EUGENE CHANEY JR</u>				Address <u>WALDORF, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO <u>161X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized metastases</u> DUE TO <u>Carcinoma of larynx</u> cause last. (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>3 yrs</u> <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>30 June 1967</u> to <u>30 June 1967</u> , that (I) (we) last saw the deceased alive on <u>30 June 1967</u> , and that death occurred at <u>6:34</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>R. J. Jarner</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>30 June 67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHRIST CHURCH</u>	
23d. LOCATION (City, town or county) <u>Owensville Md</u>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>HARDESTY Funeral Home, Gatesville, Md</u>				ADDRESS <u> </u>		25a. REC'D BY REGISTRAR <u>JUL 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>							

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Page 3 (over)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07574

07552

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 6 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt 1 Box 73		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Helen Last COATES				4. DATE OF DEATH Month June Day 21 Year 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 2, 1905		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Acomach Co Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert Smith				14. MOTHER'S MAIDEN NAME Betty Lacader			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Benjamin Coates Rtl, Arnold, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Pulmonary Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 12, 1967 to June 21, 1967 , that (I) (we) last saw the deceased alive on June 21, 1967 , and that death occurred at 5:35 PM M. from causes and on the date stated above.							
22a. SIGNATURE R. L. Richardson				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/23/67	
22c. PHYSICIAN'S NAME (Type) R. L. Richardson, MD				22d. ADDRESS 110 Clay St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/67		23c. NAME OF CEMETERY OR CREMATORY Carpenters Hill		23d. LOCATION (City or Town) (County) (State) A.A. Co Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md				25a. REC'D BY REGISTRAR DATE 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Box 72

Box 72

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Box 72

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Box 72

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove author papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>															
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 Carver Street					d. STREET ADDRESS 15 Carver Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle HENRY Last COLBERT					4. DATE OF DEATH Month June Day 15 Year 1967										
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26-1905		9. AGE (In years last birthday) 62 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th>IF UNDER 1 YEAR</th> <th>IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Utilities retired U.S. Naval Acad.				10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Acad.		11. BIRTHPLACE (County & State, or foreign country) A.A.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard A. Colbert					14. MOTHER'S MAIDEN NAME Margaret Cook										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 219-16-0627		17. INFORMANT Address Alitheia V. Colbert-15 Carver St. Anna. Md.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinson's Disease 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH 10 years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>June 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 15</u> , 19 <u>67</u> , and that death occurred at <u>730</u> M, from the causes and on the date stated above.															
22a. SIGNATURE 					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-17-67								
22c. PHYSICIAN'S NAME (Type) R.L. Richardson					22d. ADDRESS 110 Clay St. Annapolis, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 19-67		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn Memorial Park		23d. LOCATION (City, town or county) (State) Bestgate Rd. Annapolis, Md.									
24. FUNERAL DIRECTOR ADDRESS C.E. Hicks 111 Annapolis, Md.					25a. REC'D BY REGISTRAR DATE JUN 20 1967		25b. REGISTRAR'S SIGNATURE 								

525

1964-1965

Figure 1

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12-13-01

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07576

CERTIFICATE OF DEATH

07554

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 02-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 1517 Riverdale Drive			
3. NAME OF DECEASED (Type or print) First Alicevelyn Middle W Last COLETTA				4. DATE OF DEATH Month June Day 1 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1916		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Van Buren, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME DANIEL W. WARNER				14. MOTHER'S MAIDEN NAME NOVA G. FRAZIER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 216 32 2705		17. INFORMANT Address PAOLO E COLETTA #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with widespread metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 3yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 6/1 , 19 67 , that (I) (we) last saw the deceased alive on 5/1 19 67 , and that death occurred at 11:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE <i>Richard N. Peeler</i>				22b. DATE SIGNED June 1, 1967		22c. PHYSICIAN'S NAME (Type) Richard N. Peeler M. D.	
22d. ADDRESS 121 Cathedral St., Annapolis, Md.				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-5-1967		23c. NAME OF CEMETERY OR CREMATORY BAKTO. NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.	
24. FUNERAL DIRECTOR <i>John M. Long</i>				25a. REC'D BY REGISTRAR JUN 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

07525

CERTIFICATE OF DEATH

07525

(Last Name) Ann (Arndt) Arndt
 (First Name) Ann
 (Date of Birth) July 17, 1918
 (Place of Birth) St. Louis, Missouri
 (Sex) Female
 (Race) White
 (Date of Death) June 1, 1991
 (Place of Death) St. Louis, Missouri
 (Cause of Death) Heart Disease
 (Signature) Dr. [illegible]
 (Witness) [illegible]
 (Registrar) [illegible]

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths for the City of St. Louis, Missouri, on June 1, 1991.
 Registrar of Deaths
 City of St. Louis, Missouri
 June 1, 1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07577

CERTIFICATE OF DEATH

07555

1. PLACE OF DEATH a. COUNTY <i>Ad. Ad.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adenton</i> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Ad. Ad.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adenton</i> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jane</i> First <i>Conaway</i> Middle Last 4. DATE OF DEATH <i>6</i> Month <i>1</i> Day <i>1967</i> Year		5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col.</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-2-1891</i>		9. AGE (In years last birthday) <i>76</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>Richard Togood</i>		14. MOTHER'S MAIDEN NAME <i>Claudia Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>219-099582</i>		17. INFORMANT <i>Rev. Harry Conaway</i> Address <i>Adenton MD.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>441X</i> <i>Uremia</i> DUE TO <i>Cardio Vasc. Terminal Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Edema</i> (c) <i>Malig. Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>2 1/2</i> <i>1 1/2</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>3-1-65</i> , that (I) (we) last saw the deceased alive on <i>5/23/67</i> , and that death occurred at <i>5A</i> M, from causes and on the date stated above.					
22a. SIGNATURE <i>Joseph Lipskey M.D.</i>		22b. DATE SIGNED <i>June 1-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKEY M.D.</i>		22d. ADDRESS <i>Adenton MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-4-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Macadonia Adenton MD.</i>	
23d. LOCATION (City or town) (County) (State)					
24. FUNERAL DIRECTOR <i>William Reese #111111</i>		25a. REC'D BY REGISTRAR <i>JUN 7 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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6/19-R/S-

07578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07556

1. PLACE OF DEATH a. COUNTY <u>P.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marly Park Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marly Park (Glen Burnie)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDEL Hosp.</u>				d. STREET ADDRESS <u>506 Oak Avenue Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>William R.</u> Middle <u>Cook</u> Last <u>St.</u>				4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1902</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Man (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Cook</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Tark</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-18-3502</u>		17. INFORMANT <u>Mrs. Arlette F. Cook (wife)</u> Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Linhardt</u> EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <u>6-18-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
<u>Burial</u>		<u>June 21, 1967</u>		<u>Cedar Hill Cem.</u>		<u>Brooklyn, RFD, Md.</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>		ADDRESS <u>Singleton Funeral Home</u> <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07579

07557

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Broadwater Road	
3. NAME OF DECEASED (Type or print) First Leroy Middle (none) Last CRANDALL		4. DATE OF DEATH Month June Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM		10b. KIND OF BUSINESS OR INDUSTRY LAND	
11. BIRTHPLACE (County & State, or foreign country) Churchton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William B. Crandall		14. MOTHER'S MAIDEN NAME Margaret Owings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. #2	
17. INFORMANT Myrtle Crandall		Address #2	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of larynx. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 161X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 9, 19 67 to June 9, 19 67 that (I) (we) lost saw the deceased alive on June 9, 19 67 , and that death occurred at 6:15 AM M, from causes and on the date stated above.			
22a. SIGNATURE Richard M. Peeler		22b. DATE SIGNED 6/10/67	
22c. PHYSICIAN'S NAME (Type) RICHARD M. PEELER		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-12-67	23c. NAME OF CEMETERY OR CREMATORY Quaker Cemetery	23d. LOCATION (City or Town) (County) (State) Palesville Md.
24. FUNERAL DIRECTOR John M. Layla & Sons Annapolis, Md.		25. REC'D BY REGISTRAR Charles Judge	
25a. DATE JUN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07558		07558	
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 904 Carrollton Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 904 Carrollton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUIS MAE CULLY		4. DATE OF DEATH June 29 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY *****	9. AGE (In years last birthday) 66 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas McPherson		14. MOTHER'S MAIDEN NAME Jessie Queen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edward G. Cully-904 Carrollton Ave.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443X DUE TO H. A. C. V. D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus mild	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 mos 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/12 1958 to June 29 1967 , that (I) (we) last saw the deceased alive on June 29 1967 , and that death occurred at 1140 M. from the causes and on the date stated above.			
22a. SIGNATURE Faye W. Allen		22b. DATE SIGNED 6/30/67	
22c. PHYSICIAN'S NAME (Type) FAYE ALLEN		22d. ADDRESS 62 Cathedral St. Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 3-67	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City, town or county) (State) Annapolis, Md.
24. FUNERAL DIRECTOR C.E. Hicks 111		25a. REC'D BY REGISTRAR JUL 3 1967	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07559

1. PLACE OF DEATH a. COUNTY <u>Ad. Ad.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Ad. Ad.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ad. Ad. General</u>		d. STREET ADDRESS <u>R.F.D. 3 - Box 44</u>	
3. NAME OF DECEASED (Type or print) <u>Leonard</u> First <u>Curry</u> Middle Last		4. DATE OF DEATH Month <u>6</u> - Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/1903</u>
9. AGE (In years, months, and days) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Curry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Carrie Jackson</u>		Address <u>Balto. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Caduta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F.L. Wharrett</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <u>6/25/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-29-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Annapolis</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Anna M. K.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 27 1967</u>	

Chas. H. ...

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Chas. H. ...

Chas. H. ...

Chas. H. ...

Chas. H. ...

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07582

07560

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospt. DOA</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u> d. STREET ADDRESS <u>POUNDER COVE RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joyce L. Curtin</u>		4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES HENRY REYNOLD</u>		14. MOTHER'S MAIDEN NAME <u>ETHEL MAE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JAMES E. Curtin</u>		Address <u>#2</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARRHYTHMIA</u> <u>H201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>66</u> , to <u>6/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> , 19 <u>67</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>General Bhuvah</u>		22b. DATE SIGNED <u>6/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CONRAD C. HUACH</u>		22d. ADDRESS <u>121 CATTENHAR ST ANNAPOLIS MD</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1583

CERTIFICATE OF DEATH

CHARLES HENRY WATSON
Born [illegible]
Died [illegible]
Cause of Death [illegible]
Place of Death [illegible]
Buried at [illegible]
Interment [illegible]

[Faint, mostly illegible text, likely a continuation of the certificate or a separate document page.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07583

07561

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park, Severn,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The North Arundel Hospital				d. STREET ADDRESS Route 1, Box 360 A			
3. NAME OF DECEASED (Type or print) First Middle Last HARRY DAY				4. DATE OF DEATH Month Day Year June 20, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Sept. 1904	9. AGE (In years last birthday) 62 6/12 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Heavy Equipment		11. BIRTHPLACE (State or foreign country) Gladwin, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd Day				14. MOTHER'S MAIDEN NAME Minnie Long			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mabel A. Day, same as 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8/161 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car stuck by truck					
20c. TIME OF INJURY Hour a.m. Month, Day, Year 6:48 xx 6/20 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) street		20f. (City or town) (County) (State) Glen Burnie, Anne Arundel	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D.		Address (Street, city, town, or county)		22. DATE SIGNED 6/20/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 24 June 67		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Parsons, W. Va.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR JUN 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

<div> <div>1</div> <div> <div>07584</div> <div>07562</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>6 Dogwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Bergen</u> Last <u>Dearth</u>					4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1967</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>Caus.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2, 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teacher (ret.)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>public school</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dunbar Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Aaron Dearth</u>					14. MOTHER'S MAIDEN NAME <u>Eliza Jane Woodward</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>188-36-0297</u>		17. INFORMANT <u>George G. Dearth - same as #2 above</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> (b) <u>Anteroseptal Heart Disease</u> (c) <u>unburn</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1967</u> , to <u>6/13, 1967</u> , that (I) (the) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, MD</u>					22d. ADDRESS <u>16 Murray Ave., Annapolis, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial June 17, 1967</u>			23b. DATE THEREOF <u>June 17, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sylvan Heights Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Uniontown, Fayette Co. Pa.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deverly E. Hopping</u> ADDRESS <u>HOPPING FUNERAL HOME * ANNAPOLIS, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>JUN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION

07880

07880

1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07585

CERTIFICATE OF DEATH

07563

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Manor Nursing Home</u>				d. STREET ADDRESS <u>Rte. 2, Box 190</u>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Emmanuel</u> Last <u>Dicus</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 July 1890</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William H. Dicus</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Greeh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>William E. Dicus, 3129 Rheims Road, Balto. 7</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO <u>Ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u> </u> DUE TO <u>Coronary arteriosclerosis with occlusion</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic nephrosclerosis, Diabetes mellitus, Azotemia with anemia, Congestive heart failure (chronic)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 minutes</u> <u>several years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9 February, 1967</u> to <u>17 June, 1967</u> , that (I) (we) last saw the deceased alive on <u>11 June, 1967</u> , and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles W. Kinzer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>19 June 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>				22d. ADDRESS <u>16 Murray Av., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>21 June 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Maryland</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 22 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2a,b,c & d Film #G389 6/16/67 pc

07586

CERTIFICATE OF DEATH

07564

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> N.Y. b. COUNTY <u>H/H.</u> King Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> Brooklyn <u>69-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		d. STREET ADDRESS <u>101 Lafayette Ave.</u> <u>BAY RIDGE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M</u> Last <u>Dornheim</u>		4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-1881</u> 86
9. AGE (In years last birthday) yrs. <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>BROOKLYN, N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>HENRY DORNHEIM</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA ECHINGER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>100 AMERICANA DR.</u>		17. INFORMANT <u>E.H. DORNHEIM</u> <u>ANNAPOLIS, M.D.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASTRO-INTESTINAL HEMORRHAGE</u> <u>575X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE & DIGESTIVE FAILURE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>65</u> , to <u>6/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/8</u> , 19 <u>67</u> , and that death occurred at <u>4:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Beck</u> PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <u>6/11/67</u>	
22c. ADDRESS		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>BURIAL</u>		<u>6-14-67</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>LUTHERAN CEMT.</u>		<u>BROOKLYN</u> <u>N.Y.</u>	
24. FUNERAL DIRECTOR <u>John M. Taylor</u>		25a. REC'D BY REGISTRAR <u>John M. Taylor</u>	
25b. REGISTRAR'S SIGNATURE <u>John M. Taylor</u>		25c. DATE <u>JUN 14 1967</u>	

03888

03888

W. J. W. W. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07587

CERTIFICATE OF DEATH

07565

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>			c. LENGTH OF STAY IN 1b <u>1 wk</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Nursing Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edgar</u> Last <u>Dove</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5th</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Bus Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Friendship Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James I Dove</u>				14. MOTHER'S MAIDEN NAME <u>Laura Sherbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bessie B. Dove Edgewater Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypostatic pneumonia</u> 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial insufficiency</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1967</u> , to <u>June 5, 1967</u> ; that (I) (we) last saw the deceased alive on <u>June 1st</u> 1967, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>Emily H. Lukin</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Wadesville Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Buried</u>		<u>6-7-67</u>		<u>Woodsfield</u>		<u>Galesville A.A. Co.</u>	
24. FUNERAL DIRECTOR <u>Bernard L. Hardisty Galesville Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07588

CERTIFICATE OF DEATH

07566

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade, Md.			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough AH				d. STREET ADDRESS 7 Bristol Place DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Robert Middle John Last Dunleavy				4. DATE OF DEATH Month June Day 29 Year 19 67				
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 July 1918		9. AGE (In years last birthday) yrs. 48	10. IF UNDER 1 YEAR Months 02 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) Phila, Pa.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Paul J. Dunleavy				14. MOTHER'S MAIDEN NAME Jennie Judge				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 11 Feb 41-29 Jun 67 213-16-4301		17. INFORMANT Extracted from 201 File by personnel Clerk, USASA Sup Gp, FGGMD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Descending Coronary Artery Thrombosis 4201 DUE TO (b) with recent infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (b) (this hospital) attended the deceased from DOA , 18 for 29 Jun , 19 67 that (1) (we) last saw the deceased alive on 18 , and that death occurred on 1:25 PM , from causes and on the date stated above.								
22a. SIGNATURE Joseph C. Di Marco M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 29 June 1967		
22c. PHYSICIAN'S NAME (Type) JOSEPH C. DI MARCO, CPT, MC				22d. ADDRESS Kimbrough AH, Ft Geo G. Meade, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-5-67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.		
24. FUNERAL DIRECTOR John M. Taylor, Sons Annapolis Md				25a. REC'D BY REGISTRAR JUL 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

7552

UNITED STATES OF AMERICA

THE AIR FORCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07589

07567

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE			c. LENGTH OF STAY in 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS 1706 E. FORREST AVE			
3. NAME OF DECEASED (Type or print) First JULIE Middle LYNN Last EGGLETON		4. DATE OF DEATH Month JUNE Day 18 Year 19 67		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 19 DEC 1965		9. AGE (In years last birthday) 1 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman L. Eggleton				14. MOTHER'S MAIDEN NAME Margaret L. Moss			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (father) Address Ft Geo G. Meade, Md Norman L. Eggleton, 1706 E. Forrest Ave,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROCEPHALUS, POST VENT - ATRIO VALVE 3441 DUE TO INSTALLATION X2 - OBSTRUCTED INTERNAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased xxx WAS DOA, xx, xx, xxx , and that death occurred at 4:55 M, from causes and on the date stated above.							
22a. SIGNATURE Harold T. Becker				22b. DATE SIGNED 18 JUNE 1967		22c. PHYSICIAN'S NAME (Type) HAROLD T. BECHER, CPT, MC	
22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF June 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Vernon Cemetery		23d. LOCATION (City or Town) (County) (State) Teays Valley, West Virginia	
24. FUNERAL DIRECTOR Harold A. Wade, Jr., Md				25a. REC'D BY REGISTRAR JUN 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2522

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY REPORT

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PLANT INDUSTRY REPORT

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07590

CERTIFICATE OF DEATH

07568

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 1133 EASTPORT TERRACE 1520 Forest Drive			
3. NAME OF DECEASED (Type or print) First James Middle B. Last FARRELL				4. DATE OF DEATH Month June Day 8 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1899		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during major working life, even if retired) FARM		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State, or foreign country) Calvert Co, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles B. Farrell				14. MOTHER'S MAIDEN NAME SARAH ROBINSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT SARAH E. FARRELL #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 11/21 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic CARDIOVASCULAR DISEASE DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from _____, 19____, to June 8 , 19 67 that (I) had last saw the deceased alive on June 8 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE Robert O. Biern				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4:30 PM		22b. DATE SIGNED 6/9/67	
22c. PHYSICIAN'S NAME (Type) Robert O. Biern, M.D.				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		6-12-67		St. Mary's		Annapolis P.A. Md.	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR JUN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #10a, & b, 11, 12, 13, 14, 15, 16 & 17 Film #G389 6/15/67

07591

CERTIFICATE OF DEATH

07569

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Gardens - Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 200 Glen Road		d. STREET ADDRESS 200 Glen Road	
3. NAME OF DECEASED (Type or print) HARRY D FEITZ		4. DATE OF DEATH Month June Day 8 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1906
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shell Maker		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt Supplies	
11. BIRTHPLACE (County & State, or foreign country) Old Forge, Pa.		12. CITIZEN OF WHAT COUNTRY? U.A.A.	
13. FATHER'S NAME Peter		14. MOTHER'S MAIDEN NAME Harriet Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none		16. SOCIAL SECURITY NO. 206-10-0710	
17. INFORMANT Miss Geraldine Feitz		Address 200 Gelnn Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis perenal 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Of lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 to June , 19 67 , that (I) (we) last saw the deceased alive on June 5 1967, and that death occurred at 7:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Joseph Taler		22b. DATE SIGNED 6/8/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER, M.D.		22d. ADDRESS 95 ARVAHART Rd. Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Forest Home Cemetery	23d. LOCATION (City or Town) (County) (State) Taylor, Pa.
24. FUNERAL DIRECTOR Tickner Funeral Home, Baltimore, Maryland		25a. REC'D BY REGISTRAR J Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JUN 12 1967	

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07592

CERTIFICATE OF DEATH

07570

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>107 Archwood Ave.,</u>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Crutchley</u> Last <u>FELDMEYER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1892</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>OWENSVILLE, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN T. CRUTCHLEY</u>				14. MOTHER'S MAIDEN NAME <u>ALICE SEARS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>FRED FELDMEYER SR. #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(physician)</u> attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>June 19, 1967</u> , that (I) <u>(X)</u> lost saw the deceased alive on <u>June 19</u> 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>John L. Hedeman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John L. Hedeman, M.D.</u>				22d. ADDRESS <u>1407 Forest Drive, Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis A.H. Md.</u>	
24. FUNERAL DIRECTOR <u>John M. Lyons Sons Annapolis, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1552

STATE OF OHIO

IN SENATE, JANUARY 1, 1902.

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE

YEAR 1901

AND

1902

HOME

John T. Cratchley

Alice Sears

Fred Feldmeyer 26. #2

NO

Revised 1925-27
Hillcrest
Annapolis, Md.

Annapolis A. A. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G309 6/11/67 pc

07593

CERTIFICATE OF DEATH

07572

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>RFD Rt 5 St. Margarets</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Fleetwood</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/4/11</u>	
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Margarets Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown John Fleetwood</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Nettie Stevens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Hospital Registrar</u>				Address <u>St. Margarets</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoidal Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio vascular disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/17/1966</u> , to <u>6/6/1967</u> , that (I) (we) last saw the deceased alive on <u>6/6/1967</u> , and that death occurred at <u>11:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>L. Benedict</u>				22b. DATE SIGNED <u>6/7/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-12-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Margarets Md</u>	
24. FUNERAL DIRECTOR <u>William Reese II 108 W WASH ST ANNAPOLIS</u>				25a. REC'D BY REGISTRAR <u>JUN 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-19-2006 BY SP-6 BJS/BJS

5228

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07594

CERTIFICATE OF DEATH

07573

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Crownsville</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Crownsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 84</u>				d. STREET ADDRESS <u>Box 84</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ROBERT LEE FORNEY</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>caus.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel R. Forney</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Catterton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-12-9791</u>		17. INFORMANT Address <u>Martha E. Forney - same as #2 above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/10, 1967</u> , to <u>6/29, 1967</u> , that (I) (we) last saw the deceased alive on <u>5/24 6/8 1967</u> , and that death occurred at <u>10:55 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>				22d. ADDRESS <u>16 Murray Ave, Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jul. 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Metho.</u>		23d. LOCATION (City or Town) (County) (State) <u>Millersville A.A. Md.</u>	
24. FUNERAL DIRECTOR <u>Beverley E. Hopping</u> HOPPING FUNERAL HOME - Annapolis, Maryland				25a. REC'D BY REGISTRAR DATE <u>JUL 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

225

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23c & d Film #G390 7/10/67 ps

07595

CERTIFICATE OF DEATH

07574

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sessup</u>				c. LENGTH OF STAY IN TB <u>1 1/2 mos.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md House of Correction Hospital</u>				d. STREET ADDRESS <u>1839 East Chase St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Linwood</u> Middle <u>Fowlkes</u> Last <u>Fowlkes</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-12-1908</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labaree</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Crew, VA.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Judge</u>				14. MOTHER'S MAIDEN NAME <u>Lillian (nee Unk.)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Gladys</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic hypertensive causes -</u> <u>443X</u> DUE TO <u>-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>5-24</u> , 19 <u>67</u> , to <u>6-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-30</u> , 19 <u>67</u> , and that death occurred at <u>2nd</u> p.m., from causes and on the date stated above.							
22a. SIGNATURE <u>Rolando V. Goco, M.D.</u>				22b. DATE SIGNED <u>6-30-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Rolando V. Goco, M.D.</u>	
22d. ADDRESS <u>House of Correction</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>A.A. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Walter E. Elchman</u>				25a. REC'D BY REGISTRAR <u>DATE JUL 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Johnas Jones</u>	

01254726

01254726

RECEIVED FROM THE OFFICE OF THE ATTORNEY GENERAL

OFFICE OF THE ATTORNEY GENERAL

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07596

07575

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY in 1b <u>49 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>927 Brooks Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Fox</u> Last <u>Fox</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/98</u>		9. AGE (In years last birthday) <u>69</u> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bottle washer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gardner Milk Dairy</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown Charles Fox Sr</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Sarah Fox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12/9</u> , 19 <u>68</u> , to <u>6/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/27/1967</u> , and that death occurred at <u>9:05 M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>L. Benedict</u>				22b. DATE SIGNED <u>6/28/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Ann Arundel Cty., Md.</u>	
24. FUNERAL DIRECTOR <u>William C. March 928 E. North Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3226

CERTIFICATE OF DEATH

DAY - 1900

For

DEATH

Organic Brain Syndrome

E. J. Connelley, M.D.

Emil J.

William C. March 228 E. South Ave.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G390 6/26/67 pc

07597

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07577

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magothy Beach		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Riverside Road				d. STREET ADDRESS Rte #1, Box 320		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM WEBSTER FRANKLIN				4. DATE OF DEATH FOUND Month 6 Day 12 Year 19 67			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Dec-12		9. AGE (In years last birthday) 53.54	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Franklin				14. MOTHER'S MAIDEN NAME Lurcertia Gaither			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hattie Spencer RFD #1, Box 320			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumably drowned DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Unknown		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) Magothy Beach A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 6-14-67	
EXAMINER'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore, Natinoal Street	
24. FUNERAL DIRECTOR Isaiah L. Brown and Son-108-W. Montgomery		ADDRESS		23d. LOCATION (City or Town) (County) (State) Baltimore City		23e. REC'D BY REGISTRAR 21 1967	
				23f. REGISTRAR'S SIGNATURE Charles Judge			

7557

Jacob Franklin

Laborer

SS Jan-12

MS

Importation

Harris Spencer, MD, Box 370

6-12-87

Baltimore, Md.

James I. Brown and Son - 101 N. Broadway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 2 & 7 Film G390 7/20/67 kk
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07598

07578

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE South Carolina b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster, S.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS 103 Hampton Road	
3. NAME OF DECEASED (Type or print) First Middle Last HELEN MAE FRAZER		4. DATE OF DEATH Month Day Year 6 25 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 ? yrs.
9. AGE (In years last birthday) 21		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard FRAZER		14. MOTHER'S MAIDEN NAME Lillie M. Brooks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injuries of chest 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto which failed to make turn	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:40 xx 6 25 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #3-Harbor Tunnel Glen Burnie A.A.		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		22. DATE SIGNED 6-26-67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6-30-67	CHURCH CEMETERY	LANCASTER, S.C.
24. FUNERAL DIRECTOR JOHNSON + JENKINS		25a. REC'D BY REGISTRAR JUN 30 1967	
ADDRESS 4804 GA.AVE. NW		25b. REGISTRAR'S SIGNATURE Charles Judge	

07552

07552

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07593

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07579

1. PLACE OF DEATH a. COUNTY <u>A.A.C.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - North Avenue</u>				d. STREET ADDRESS <u>938 S. Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Douglas</u> <u>GARRISH</u>				4. DATE OF DEATH Month Day Year <u>6</u> <u>21</u> <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/54</u>	9. AGE (In years lost birthday) <u>13</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Douglas W. Garrish, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.	17. INFORMANT <u>Father - same as 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>9298</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming - nearby Creek</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>6/21</u> <u>1967</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>nearby Creek</u>		20f. (City or town) (County) (State) <u>APLES MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u> EXAMINER'S NAME (Type) <u>F. Linhardt</u>			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <u>6/21/67</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>28 June 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md.</u>		
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				25. REC'D BY REGISTRAR DATE <u>JUN 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

100-1050

POST

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07600

CERTIFICATE OF DEATH

07580

1. PLACE OF DEATH a. COUNTY <u>ANNZ ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENZRAL HOSPITAL</u>		e. STREET ADDRESS <u>128 DUKES OF GLOUCESTER ST</u>	
3. NAME OF DECEASED (Type or print) <u>BARHAM ROSCOE GARY</u>		4. DATE OF DEATH <u>JUNE 24 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-99</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Newport News, Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>B. Roscoe Gary</u>		14. MOTHER'S MAIDEN NAME <u>Willie Barham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elizabeth Joy Gary</u> Address <u>#2</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arterio sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> years.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/23, 1965, to 6/24, 1967, that (I) (we) last saw the deceased alive on 6/23, 1967, and that death occurred at 6:00 M, from causes and on the date stated above.

22a. SIGNATURE <u>General Chum</u>	22b. DATE SIGNED <u>6/24/67</u>
22c. PHYSICIAN'S NAME (Type) <u>GERMAN CHUMET</u>	22d. ADDRESS <u>121 EASTON AVE ANNAPOLIS</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>6-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>H. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Md.</u>
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24. FUNERAL DIRECTOR <u>John M. Saylor & Sons Annapolis, Md.</u>	25a. REC'D BY REGISTRAR <u>JUN 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

48-44

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

07000

RECEIVED
FBI
JAN 15 1964

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-15-2000 BY 60322
UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07601					07581				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Anne Arundel					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville					b. COUNTY Anne Arundel				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Nursing Home					d. STREET ADDRESS 531 Gladhill Rd.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. AGE (In years last birthday)			
First Middle Last GRACE WILCOX GIFFORD			Month Day Year June 24 19 67			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
female	caus.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 1, 1885	81 yrs.	Dept. Store	New Bedford, Mass.	USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk					10b. KIND OF BUSINESS OR INDUSTRY Dept. Store				
13. FATHER'S NAME Job H. Wilcox					14. MOTHER'S MAIDEN NAME Zillah Simmons				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. 030-16-8414A				
17. INFORMANT Mrs. Hope C. Ligan - same as #2 above					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 163X DUE TO Carcinoma Lung & Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Metastasis DUE TO Metastasis								INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1966 , to June 24, 1967 , that (I) (we) last saw the deceased alive on June 20, 1967 and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE Feleus Grubers						22b. DATE SIGNED 6/25/67			
22c. PHYSICIAN'S NAME (Type) Feleus Grubers						22d. ADDRESS 1113 Odenton Rd Odenton			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF June 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Bopping Funeral Home, Annapolis, Maryland			23d. LOCATION (City, town or county) (State) New Bedford Mass.	
24. FUNERAL DIRECTOR Bopping Funeral Home, Annapolis, Maryland						25a. REC'D BY REGISTRAR JUN 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1000000

RENTAL OF GRAIN

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1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07602
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07582

1. PLACE OF DEATH a. COUNTY AA CO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) glen BURNIE		c. LENGTH OF STAY IN 1b FAIRFAX station	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A - North ARUNDEL		d. STREET ADDRESS 83-3	
3. NAME OF DECEASED (Type or print) First Alfred Middle Goodspeed Last 4. DATE OF DEATH Month 6 Day 4 Year 1967		9. AGE (In years last birthday) 53 yrs.	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Clayton D. Goodspeed		14. MOTHER'S MAIDEN NAME Grace Riggles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 274-05-4082	17. INFORMANT Mrs. Catherine Feehan; Fairfax, Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 7824 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhardt EXAMINER'S NAME (Type)		22. DATE SIGNED 6-4-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/7/67	23c. NAME OF CEMETERY OR CREMATORY Fairfax Cemetery;	23d. LOCATION (City or Town) (County) (State) Fairfax, Virginia
24. FUNERAL DIRECTOR Everly Funeral Home; By <i>Onoda</i> Fairfax, Va.		25a. REC'D BY REGISTRAR JUN 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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doi:10.1017/S0022292412001910 Printed in the United Kingdom

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07603

CERTIFICATE OF DEATH

07583

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore city</u>	
c. LENGTH OF STAY IN 1b <u>2-16-60 to 6-9-67</u>		d. STREET ADDRESS <u>1402 Riggs Avenue Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GRIFFIN, SAMUEL</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-1915</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe maker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A. Phil PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CRIFFIN John</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownville State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>473X</u> <u>uremia and heart failure</u> DUE TO (b) <u>Pneumonia, Congestive heart failure</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5-31-67 to 6-9-67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestive heart failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-16</u> , 19 <u>60</u> , to <u>6-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-9</u> , 19 <u>67</u> , and that death occurred at <u>4:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. G. Lakshman Rao</u>		22b. DATE SIGNED <u>6-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. G. LAKSHMAN RAO</u>		22d. ADDRESS <u>CROWNVILLE STATE Hospital, Crownville, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto</u> <u>MD</u>
24. FUNERAL DIRECTOR <u>Pinegold Funeral Home</u>		25a. REC'D BY REGISTRAR <u>14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2500

STATE OF TEXAS

County of ...

Know all men by these presents, that ...
for and to the use of ...
the sum of ... Dollars ...
to have and to hold unto the said ...
with all and singular the rights and appurtenances thereto in anywise by law in anywise coming to the said ...
unto the said ...
I, the undersigned, the said ...
do hereby certify that the foregoing is a true and correct copy of the original as the same appears from the records of the County Clerk of the County of ... State of Texas.

CLERK OF COURT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07604

07584

1. PLACE OF DEATH a. COUNTY <u>ANCO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
c. LENGTH OF STAY in 1b <u>LIFE</u>				d. STREET ADDRESS <u>Solomons Island Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Anne Arundel Gen.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Harris</u> Last <u>HARRIS</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/26/08</u>		9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>City</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Harris</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Delroyd E Harris St. Margarets Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7831</u> DUE TO <u>Pulmonary Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>E Lir Linn St.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>6-2-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Henderson Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Margarets AA Md</u>	
24. FUNERAL DIRECTOR <u>Johansen's Funeral Home Ann. Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James Jones</u>	

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Came to" and "Dulwich" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07605

CERTIFICATE OF DEATH

07585

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASEDENA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL				d. STREET ADDRESS Box 250, Rt 6, high Point		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia M Harrison				4. DATE OF DEATH Month Day Year June 30 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-80		9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) Knigsville, Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME THOMAS OLIVER BLAIR				14. MOTHER'S MAIDEN NAME VIRGINIA M. BURGEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-54165		17. INFORMANT FAMILY - Box 250-Rt. 6, PASEDENA Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Central Hemorrhage DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-24 , 1967, to 6-30 , 1967, that (I) (we) last saw the deceased alive on 6-30 , 1967, and that death occurred at 11 P.M. from causes and on the date stated above.							
22a. SIGNATURE Adrian M. Kelly				22b. DATE SIGNED 7-1-67		22c. PHYSICIAN'S NAME (Type) J. Shalter Gaskin	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-3-1967		23c. NAME OF CEMETERY OR CREMATORY GLENHAVEN MEM. PK		23d. LOCATION (City or Town) (County) (State) ANN ARUNDEL Co.	
24. FUNERAL DIRECTOR J. Shalter Gaskin				25a. REC'D BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE J. Charles Yager	

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Central Laboratory

Central Laboratory

Handwritten signature

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RECEIVED
11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07606

CERTIFICATE OF DEATH

07586

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY in 1b 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt-4, Box-53			
3. NAME OF DECEASED (Type or print) First Arne Middle Olaf Last HAUGLAND				4. DATE OF DEATH Month June Day 14 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1895	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 7 Days 14 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Mariner - ret.		10b. KIND OF BUSINESS OR INDUSTRY Martime		11. BIRTHPLACE (County & State, or foreign country) Trondjein Norway		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anton Haugland				14. MOTHER'S MAIDEN NAME Karen C. Brekke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 082-14-9413		17. INFORMANT Address Mary Anna Haugland - same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widened metastatic carcinoma of prostate. 197X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from July , 1958, to June 14 , 1967, that (I) (the doctor) saw the deceased alive on June 14 , 1967, and that death occurred at 10:45 PM M, from causes and on the date stated above.							
22a. SIGNATURE John L. Hedeman				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/15/67	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman, M.D.				22d. ADDRESS 1407 Forest Drive, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF June 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Beverly E. Hopping HOPPING FUNERAL HOME				25a. REC'D BY REGISTRAR JUN 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

325

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Millersville c. LENGTH OF STAY IN lb 7 Wks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knoll Wood Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY A.A.Co c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 618 Bay Ridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen First Middle Last NMN 4. DATE OF DEATH June 6, 19 67 Month Day Year		5. SEX Female 6. CDOLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 1-1900 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Prince George Co, Md 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hebron 14. MOTHER'S MAIDEN NAME Emily Carroll		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 25-32-0227 17. INFORMANT James Hebron Bx 52 Rt 2 Mitchellville Address Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 410X DUE TO Mitral Stenosis and insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic fever DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH several months many years since childhood	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, general, coronary and cerebral. Left bundle branch block, Atrial fibrillation, Renal insufficiency, Anemia			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 18, 19 67 , to Jun 6, 19 67 , that (I) (we) last saw the deceased alive on 21 May, 19 67 , and that death occurred at 2 PM , from the causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED June 6, 1967	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS 16 Murray Ave., Annapolis, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/1967	
23c. NAME OF CEMETERY OR CREMATORY Arbutus		23d. LOCATION (City, town or county) (State) Baltimore, Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111		25a. REC'D BY REGISTRAR JUN 14 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07608

CERTIFICATE OF DEATH

07588

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lombardes Beach				d. STREET ADDRESS 401 Balto. Annap. Blvd N/W		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) August G. Hein, Sr.				4. DATE OF DEATH Month JUNE Day 6 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1902	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 19 Min.		11. BIRTHPLACE (County & State, or foreign country) Fairfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10b. KIND OF BUSINESS OR INDUSTRY Fuel Oil		11. BIRTHPLACE (County & State, or foreign country) Fairfield, Maryland	
13. FATHER'S NAME John Hein				14. MOTHER'S MAIDEN NAME Anna Grothey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216/05/8659		17. INFORMANT Mrs. Helen A. Hein		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL VARICES DUE TO (b) LAENNETT'S CIRRHOSIS + HEPATOMA DUE TO (c) 5811 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 36 HRS 3 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 19 54 , to JUNE 6 19 67 , that (I) (we) last saw the deceased alive on MAY 22 19 67 , and that death occurred at 9:15P M, from causes and on the date stated above.							
22a. SIGNATURE Leon C. Perry				22b. DATE SIGNED 6-7-67		22c. PHYSICIAN'S NAME (Type) Leon C. Perry M.D.	
22d. ADDRESS 201 Balto. Annap. Blvd. N/W				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn RFD Md.	
24. FUNERAL DIRECTOR R.V. SINGLETON				25a. REC'D BY REGISTRAR GLEN BURNIE, MD.		25b. REGISTRAR'S SIGNATURE JUN 8 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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NOTES ON THE CONTRIBUTORS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07603		07589	
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE-RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-SEVERN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>RT. 2 BOX 215-1-A</u> <u>QUEENSTOWN ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle _____ Last <u>HINES</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY 1, 1921</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAND & GRAVEL CO.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE HINES</u>		14. MOTHER'S MAIDEN NAME <u>EDITH JACKSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>MISS HATTIE QUEEN</u>		Address <u>RT 2 BOX 215-1-A</u> <u>SEVERN, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Renal Disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10+ years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malignant Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-5-</u> , 19 <u>67</u> , to <u>6-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-25</u> 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Adrian J. Thorley</u>		22b. DATE SIGNED <u>6-26-67</u>	
22c. PHYSICIAN'S NAME (Type) _____		22d. ADDRESS _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore md</u>	
24. FUNERAL DIRECTOR <u>Burnell B. Aden Balto. md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
DATE <u>JUN 27 1967</u>		25b. REGISTRAR'S SIGNATURE	

00000

CERTIFICATE OF DEATH

27500

10 years
years
2

My dear Mother
Mother's name
Mother's name
Mother's name

10 years
years
2

My dear Mother
Mother's name
Mother's name
Mother's name

16

1

07610

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07590

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS BOX 56, PINE TREE ROAD	
3. NAME OF DECEASED (Type or print) First DONALD Middle HUDSON Last HUDSON		4. DATE OF DEATH Month JUNE Day 10 Year 19 67	
SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 DEC 1895
9. AGE (In years lost birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman		10b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE RET'D	
11. BIRTHPLACE (County & State, or foreign country) TOPEKA, KANSAS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PAUL HUDSON		14. MOTHER'S MAIDEN NAME AGUSTA SCHMIDT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 110-09-0004	
17. INFORMANT (wife) Mrs. Donald Hudson, Box 56, Pine Tree Rd,		Address Jessup, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 June , 19 67 , to 10 June , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10 June , 19 67 , and that death occurred at 3:20 PM , from causes and on the date stated above.			
22a. SIGNATURE George J. Rameriz		22b. DATE SIGNED 10 JUNE 1967	
22c. PHYSICIAN'S NAME (Type) GEORGE J. RAMERIZ, CPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/14/67	23c. NAME OF CEMETERY OR CREMATORY Arlington	23d. LOCATION (City or Town) (County) (State) Arlington Va
24. FUNERAL DIRECTOR Donald J. ...		25. REGISTERED BY JUN 19 1967	
26. ADDRESS ...		27. REGISTRAR'S SIGNATURE ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CONFIDENTIAL

0700

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07611

CERTIFICATE OF DEATH

07591

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>4 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u> d. STREET ADDRESS <u>Rt-4, Box-99,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ross</u> Middle <u>John</u> Last <u>HUNERLACH</u>			4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>19 67</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1964</u>	9. AGE (In years last birthday) <u>2</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>n/a</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>n/a</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis Maryland</u>			
13. FATHER'S NAME <u>George Robert Hunerlach</u>			14. MOTHER'S MAIDEN NAME <u>Raymonde Grace Newkirk</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>n/a</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>George R. Hunerlach</u> Address <u>1964 Brightseat Rd. Landover, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> DUE TO (b) <u>Acute laryngeal tracheitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 18, 1967</u> to <u>June 18, 1967</u> that (I) (we) last saw the deceased alive on <u>June 18, 1967</u>, and that death occurred at <u> </u> M. from causes and on the date stated above.					
22a. SIGNATURE <u>Antonio M. Rivera</u>			22b. DATE SIGNED <u>19 June 67</u>		22c. PHYSICIAN'S NAME (Type) <u>Antonio M. Rivera, M.D.</u>		
22d. ADDRESS <u>South Reiv Med Cent., Edgewater, Md.</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Margarets Epis. Co. St. Margarets</u>			
23d. LOCATION (City or Town) (County) (State) <u>Annapolis Md.</u>		24. FUNERAL DIRECTOR <u>Beverly E. Hopping</u> ADDRESS <u>Hopping Funeral Home - Annapolis, Md.</u>					
25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MINUTE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07612		07592	
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS P. O. Box 201	
3. NAME OF DECEASED (Type or print) First Robert Middle Gorden Last JARDINE		4. DATE OF DEATH Month June Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1895
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. Foreman		10b. KIND OF BUSINESS OR INDUSTRY Tree Trimming	
11. BIRTHPLACE (County & State, or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME CHAS KNOX		14. MOTHER'S MAIDEN NAME CHAS KNOX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 196-01-4740	
17. INFORMANT Mrs. Lena Jardine - same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis 5870 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None known		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 June, 1967 , to 27 June, 1967 , that (I) (we) last saw the deceased alive on 27 June, 1967 , and that death occurred at 1:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED 28 June 1967	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS 16 Murray Av., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 30, 1967	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.	
24. FUNERAL DIRECTOR Beverly E. Hopping HOPPING FUNERAL HOME - Annapolis, Maryland		25a. REC'D BY REGISTRAR JUN 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07613

CERTIFICATE OF DEATH

07598

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 19 Ricket Road, Seton</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ricket Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Aghes</u> Middle <u>M</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12 1892</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>(Unknown) Shaeffer</u>			14. MOTHER'S MAIDEN NAME <u>Ida (Unknown)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Leonard Johnson</u> Address <u>Box 19 Ricket Road Seton</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 260x DUE TO <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>present</u> , that (II) (we) last saw the deceased alive on <u>6-8</u> 19 <u>67</u> and that death occurred at <u>1A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Jose M. Yasuico</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-8-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Jose M. Yasuico M.D.</u>			22d. ADDRESS <u>704 Garman Ave., Laurel, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Brooklyn PFD, Md.</u>	
24. FUNERAL DIRECTOR <u>R. K. Singleton</u>		ADDRESS <u>Singleton funeral home</u>		25. REG. BY REGISTRAR <u>June 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Juage</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000

03518

For (N, K, n, α, β)

(Unknown) Sheet 1

1. *Quercus*
 2. *Pinus*
 3. *Larix*
 4. *Juniperus*
 5. *Cedrus*
 6. *Thuja*
 7. *Abies*
 8. *Picea*
 9. *Taxus*
 10. *Podocarpus*
 11. *Sciadopitys*
 12. *Sequoia*
 13. *Metasequoia*
 14. *Keteleeria*
 15. *Nothofagus*
 16. *Agathis*
 17. *Widdowsonia*
 18. *Phyllocladus*
 19. *Podocarpus*
 20. *Sciadopitys*
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 22. *Metasequoia*
 23. *Keteleeria*
 24. *Nothofagus*
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 221. *Keteleeria*
 222. *Nothofagus*
 223. *Agathis*
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07614

07594

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 418 Chesapeake Ave.			
3. NAME OF DECEASED (Type or print) First Hester Middle Victoria Last JOHNSON				4. DATE OF DEATH Month June Day 22 Year 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1890		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 6 Days 10 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Isaac Johnson				14. MOTHER'S MAIDEN NAME Hester Lane			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Pearl Turner Address #13 Chestnut			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Block - C.V.A. (x2) 4330 DUE TO (b) A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH 6 mos 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia, possibly tuberculous; severe decubitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 67 to 6-22 , 19 67 that (I) (we) last saw the deceased alive on 6-22 , 19 67 , and that death occurred at 4:15 P.M. from causes and on the date stated above.							
22a. SIGNATURE John F. Verloop				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-23-67	
22c. PHYSICIAN'S NAME (Type) William Reese				22d. ADDRESS 1407 Ford Dr. Annapolis, Md 21403			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-26-67		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis Md	
24. FUNERAL DIRECTOR William Reese				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

BP 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07613					07595						
1. PLACE OF DEATH a. COUNTY <i>Annapolis</i>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Annapolis</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>A. A. General</i>					d. STREET ADDRESS <i>35 Larkin</i>						
3. NAME OF DECEASED (Type or print) <i>PHILIP</i>					4. DATE OF DEATH Month <i>6</i> Day <i>6</i> Year <i>1967</i>						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-7-1898</i>		9. AGE (In years last birthday) <i>69</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME <i>Charlie Johnson</i>					14. MOTHER'S MAIDEN NAME <i>Mary Jennings</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.						
17. INFORMANT <i>Elizabeth Johnson</i>					Address <i>35 Larkin</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>163X</i> DUE TO <i>Cocci of lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>163X</i> DUE TO <i>163X</i> (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1/6/67</i> , 19 <i>67</i> , to <i>6/6</i> , 19 <i>67</i> ; that (I) (we) last saw the deceased alive on <i>6/6/67</i> 19 <i>67</i> , and that death occurred at <i>6</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Gerard Blumel</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF <i>6-10-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		23d. LOCATION (City, town or county) (State) <i>Annapolis Md.</i>		
24. FUNERAL DIRECTOR <i>William Reese #</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>					25b. REGISTRAR'S SIGNATURE	
ADDRESS <i>Annapolis</i>					DATE <i>JUN 9 1967</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If necessary, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
07616						CERTIFICATE OF DEATH						07598	
1. PLACE OF DEATH a. COUNTY AA Co						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY AA Co							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover						c. LENGTH OF STAY IN 1b MARYLAND							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 125 Ridge Rd Hanover, Md						d. STREET ADDRESS 125 Ridge Rd						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosa First Kadan Middle Kadan Last						4. DATE OF DEATH June Month 11 Day 19 Year 67							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 6.1874		9. AGE (In years, not birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Mln.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Australia				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Kadan						14. MOTHER'S MAIDEN NAME Barbara Kundrot							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Theresa Scott				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Disease 443 X DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 10-14	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/11 , 19 67 , to 6/11 , 19 67 , that (I) (we) last saw the deceased alive on 6/11 , 19 67 , and that death occurred at 5 P M, from the causes and on the date stated above.													
22a. SIGNATURE Charles L. Ball												22b. DATE SIGNED 6/14/67	
22c. PHYSICIAN'S NAME (Type) Charles L. Ball						22d. ADDRESS Kenthmore Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/14/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill				23d. LOCATION (City, town or county) (State) AA CO Md			
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225						25a. REC'D BY REGISTRAR JUN 14 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07617

CERTIFICATE OF DEATH

07597

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>1611 Cedar Park Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John R. Kaiser</u>		4. DATE OF DEATH Month Day Year <u>June 12 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1893</u>
9. AGE (In years last birthday) <u>73 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. Rudolph KAISER</u>		14. MOTHER'S MAIDEN NAME <u>MARY STRANGE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WWT</u>	
17. INFORMANT <u>Virginia T. KAISER</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured gangrenous appendicitis c</u> 5501 DUE TO <u>abscess and peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr.</u> , 19 <u>47</u> , to <u>June 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 12 1967</u> , and that death occurred at <u>6:38 a.m.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>S. Borssuck</u> M.D.		22b. DATE SIGNED <u>6/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.,</u>		22d. ADDRESS <u>Amos Garrett Blvd., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis A.A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. L...</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 16 1967</u>	

10017

10017

R.

UNIT SERVICE U.S. GOV

J. RUDOLPH KAISER

yes - wwi

MARY STANLEY
VIRGINIA T. KAISER

UNITED STATES GOVERNMENT
JULY 24 1917
J. RUDOLPH KAISER, JR.

ANNOUNCED A.A. 110

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07618

CERTIFICATE OF DEATH

07598

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Annapolis		c. LENGTH OF STAY IN 1b 2 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		14-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bay Manor Nursing Home (2 yrs)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Laura Krauskop Krauskopf		4. DATE OF DEATH Month June Day 29 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1871
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Jessop		14. MOTHER'S MAIDEN NAME Maria Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217 09 8154	
17. INFORMANT Mrs. Harold Smith		Address Annapolis, Md. Old Annapolis Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 8/2 , 19 65 to 6/29 , 19 67 , that (I) (we) last saw the deceased alive on 6/26 , 19 67 , and that death occurred at 4:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 6/29/67	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, MD		22d. ADDRESS 16 Murray Ave Annapolis Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.		23d. LOCATION (City or Town) (County) (State) near Chestertown, Md.	
24. FUNERAL DIRECTOR J. Wilho Wells		25a. REC'D BY REGISTRAR JUL 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07370

CERTIFICATE OF DEATH

07370

Blank certificate form with horizontal lines for text entry.

Vertical text on the right margin, including "FEDERAL BUREAU OF INVESTIGATION" and "U.S. DEPARTMENT OF JUSTICE".

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07613

CERTIFICATE OF DEATH

07599

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt. 3, Box 496			
3. NAME OF DECEASED (Type or print) First Roy Middle Fahs Last LANDIS				4. DATE OF DEATH Month June Day 12 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1896	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Joseph K. Landis				14. MOTHER'S MAIDEN NAME Mary Fauch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. May F. Landis		17. INFORMANT May F. Landis Address #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, 2 Rt bundle branch. 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus.							INTERVAL BETWEEN ONSET AND DEATH 6 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) this hospital attended the deceased from June , 19 55 , to June , 19 65 that (1) the last saw the deceased alive on 6/10 19 67 , and that death occurred at 6:30 AM M, from causes and on the date stated above.							
22a. SIGNATURE John M. Layla		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/13/67			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 6-15-67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis Md.	
24. FUNERAL DIRECTOR John M. Layla & Sons				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR JUN 14 1967	
				25b. REGISTRAR'S SIGNATURE James J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03613

Joseph K. Landis
Carpenter Building

May F. Landis
May F. Fench

1941-42-43
Hillcrest
Annapolis

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 390		MARYLAND STATE DEPARTMENT OF HEALTH	
7-20-67		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
Item #2a,b,c & d Film #0389 6/20/67 pc		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
07620		07601	
1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis/ Manhattan Beach 43.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel Hospital		d. STREET ADDRESS 1220 Tennyson Chase Home / St. Johns College e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHRISTOPHER LAWRENSEN		4. DATE OF DEATH Month June Day 12, Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-1948
9. AGE (In years lost birthday) yrs. 19		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas City, Mo.	
13. FATHER'S NAME Marvin Lawrenson		14. MOTHER'S MAIDEN NAME Constance File	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Constance Lawrenson		Address 1220 Tennyson Manhattan Bch. Calif.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 9026 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell or jumped from third story window	
20c. TIME OF INJURY Month, Day, Year 12-30 o.m. 6-12 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) College residence		20f. (City or town) Annapolis (County) AA (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED June 12, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6-14-1967	
23c. NAME OF CEMETERY OR CREMATORY H. Lincoln		23d. LOCATION (City or town) (County) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR John M. Layla & Sons		25a. REC'D BY REGISTRAR JUN 16 1967	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

10083

1537

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07621

07602

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 2 hrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Jessup	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS Rt. 1 Box 65	
3. NAME OF DECEASED (Type or print) First Lawrence Middle A. Last Lee		4. DATE OF DEATH Month 6- Day 8 Year 19 67		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-21		9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxicab Driver		10b. KIND OF BUSINESS OR INDUSTRY same		11. BIRTHPLACE (County & State, or foreign country) AA Md	
13. FATHER'S NAME Walter Lee			14. MOTHER'S MAIDEN NAME Leanah Stewart		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-02-5017		17. INFORMANT Mrs. Beatrice Lee - (same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4301 DUE TO (b) Old and acute myocardial DUE TO (c) infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE Febus G Burney		22b. DATE SIGNED 6/19/67		22c. PHYSICIAN'S NAME (Type) Febus G Burney	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A. Co., Md.		23e. REC'D BY REGISTRAR JUN 12 1967		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hwy., Baltimore					

14-00000

UNITED STATES OF AMERICA

1933

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE
TO THE SECRETARY OF THE INTERIOR
FOR THE YEAR 1933

Section 1. General Statement
The General Land Office has the honor to acknowledge the receipt of the report of the Commissioner of the General Land Office for the year 1933, and to express its appreciation for the thorough and complete manner in which the work of the office has been carried out during the past year.

Section 2. Summary of Work
The work of the General Land Office during the year 1933 has been characterized by a steady and consistent progress in all the major branches of the office's activities. The most important of these activities are the administration of the public lands, the management of the National Forest System, and the disposal of the public lands.

Section 3. Administration of the Public Lands
The administration of the public lands is one of the most important functions of the General Land Office. During the year 1933, the office has been actively engaged in the management of the public lands, and has taken a number of steps to improve the efficiency of its operations.

Section 4. Management of the National Forest System
The management of the National Forest System is another one of the major responsibilities of the General Land Office. During the year 1933, the office has been actively engaged in the management of the National Forest System, and has taken a number of steps to improve the efficiency of its operations.

Section 5. Disposal of the Public Lands
The disposal of the public lands is one of the most important functions of the General Land Office. During the year 1933, the office has been actively engaged in the disposal of the public lands, and has taken a number of steps to improve the efficiency of its operations.

RECEIVED
JAN 10 1934
U.S. DEPT. OF THE INTERIOR
GENERAL LAND OFFICE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF BIRTH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>212 Best Gate Rd.,</u>						d. STREET ADDRESS <u>212 Best Gate Rd.,</u>					
3. NAME OF DECEASED (Type or print) <u>EDWIN ROLAND LEITNER</u>						4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1967</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>caus.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 5, 1900</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State gov't.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edwin Leitner</u>						14. MOTHER'S MAIDEN NAME <u>Lydia George</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-18-5498</u>		17. INFORMANT <u>Mrs. Eleanor M. Leitner - same as #2 above</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>443X</u> DUE TO (b) <u>hypertensive arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>extensive bullus changes both lungs c severe bronchiectasis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1958</u> , to <u>6/8/67</u> , that (I) (we) last saw the deceased alive on <u>6/7</u> , <u>1968</u> , and that death occurred at <u>6</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>S. Borssuck</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.,</u>						22d. ADDRESS <u>Amos Garrett Blvd., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>		24 FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Hopping</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME * ANNAPOLIS, MARYLAND</u>						25a. REC'D BY REGISTRAR DATE <u>JUN 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Hopping</u>			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
07623											
1. PLACE OF DEATH											
a. COUNTY <u>AA CO</u> MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>											
c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.M. - Anne ARUNDEL-gen</u>											
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
e. STATE <u>MD</u> b. COUNTY <u>AA CO</u>											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>											
d. STREET ADDRESS <u>Rt 4 Box 582</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)											
First <u>Edward</u> F. Middle <u>MASON</u> Last <u>MASON</u>											
4. DATE OF DEATH											
Month <u>6</u> Day <u>26</u> Year <u>1967</u>											
5. SEX <u>M</u>											
6. COLOR OR RACE <u>W</u>											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>Sept. 22, 1907</u>											
9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bridge tender</u>											
10b. KIND OF BUSINESS OR INDUSTRY <u>State Gov't.</u>											
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>											
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>Harvey Mason</u>											
14. MOTHER'S MAIDEN NAME <u>Grace Ward</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)											
16. SOCIAL SECURITY NO. <u>218-12-9251</u>											
17. INFORMANT <u>Mrs. Betty Hardesty - same as #2 above</u> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u>											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>E. Linhardt</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6.26.67</u>											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>June 29, 1967</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>											
22d. LOCATION (City, town, or country) (State) <u>Annapolis A.A. Md.</u>											
23. FUNERAL DIRECTOR <u>Beverley E. Hopping</u> ADDRESS <u>Hopping Funeral Home - Annapolis, Maryland</u>											
24a. REC'D BY REGISTRAR <u>Charles Judge</u> 24b. REGISTRAR'S SIGNATURE											
DATE <u>JUN 30 1967</u>											

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24. FUNERAL DIRECTOR	ADDRESS
Harold S. W. L. Samuelson	

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MINUTE OF MEETING

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MEMORANDUM

TO THE BOARD

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07625

CERTIFICATE OF DEATH

07607

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt. 5, Box 209			
3. NAME OF DECEASED (Type or print) First Frances Middle DeMauriac Last MELVIN				4. DATE OF DEATH Month June Day 10 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1906		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) Jersey City, New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME PIERRE de MAURIAE				14. MOTHER'S MAIDEN NAME FRANCES WAINWRIGHT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT MALCOLM MELVIN #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant neoplasm of the ovary, acute 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sophagical obstruction DUE TO (c) Carcinomatosis, primary ovary						INTERVAL BETWEEN ONSET AND DEATH 4-6 weeks 4-6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abdominal ascites and pleural effusion, massive						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/13 , 19 67 , to 6/10 , 19 67 , that (I) (we) last saw the deceased alive on 6/10 19 67 , and that death occurred at 10:50 P.M. from causes and on the date stated above.		22a. SIGNATURE Robert A. Riley, Jr. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert A. Riley, Jr., M.D.		22d. ADDRESS 95 Cathedral St., Annapolis, Md.		22b. DATE SIGNED 6/12/67		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 6-13-67		23c. NAME OF CEMETERY OR CREMATORY DENTON CENT.		23d. LOCATION (City or Town) (County) (State) DENTON MD.		24. FUNERAL DIRECTOR John M. Taylor Annapolis, Md.	
25a. REGD BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE		25d. REGISTRAR'S SIGNATURE	

2323

CERTIFICATE OF DEATH

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No. —
 Pierre de Marillac
 Hime
 Husewife Joseph, now living
 Frances Winnefield
 Malcolm Melvin

Registered 1-13-07
 Denton Cent.
 Denton
 Md.

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MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07626

07608

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>8 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gerald</u> Middle <u>E. Mergenthaler</u> Last <u></u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-19-98</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice Pres. & Cashier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Fritz Mergenthaler</u>				14. MOTHER'S MAIDEN NAME <u>Rose L. Heise</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>217 14 1812</u>		17. INFORMANT <u>Mr. Rob't Mergenthaler (son)</u> Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Disease</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> , 19 <u>67</u> , to <u>6-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-8</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Hilary T. O'Herlihy</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hilary T. O'Herlihy</u>				22d. ADDRESS <u>65 Central Ave Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>R. J. Singleton</u>				ADDRESS <u>Singleton Funeral Home</u>		DATE <u>June 14 1967</u>	
				REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

032370

RECEIVED ON DEATH

0366350

John L. Wilson

71122 Memorial

John Wilson

MEMORIAL SERVICE FOR MR. JOHN L. WILSON

TO BE HELD AT THE CHURCH OF THE HOLY TRINITY

AT 10:00 A.M.

THE SERVICE WILL BE CONDUCTED BY THE RECTOR

AND THE CHURCH SINGERS

THE SERVICE WILL BE OPEN TO ALL

AND ALL ARE INVITED

THE SERVICE WILL BE HELD AT THE CHURCH OF THE HOLY TRINITY

AT 10:00 A.M.

John L. Wilson, 1907-1987

1987

John L. Wilson

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07609

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 0 0 A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Park - Pasadena			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA - Nor 16. ARUNDEL -				d. STREET ADDRESS Rt 7 - Box 357		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alan Middle Reid Last Miller				4. DATE OF DEATH Month 6 Day 28 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1954		9. AGE (In years last birthday) yrs. 12 1/2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Miller, James Roy				14. MOTHER'S MAIDEN NAME Mildred Krecher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address James Roy Miller - Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8124 Multiple injuries DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Broken	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto - mountain Road & French Ave					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6/28 1967 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) AACD MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. Linbaker		EXAMINER'S NAME (Type) E. Linbaker		M.D. E. Linbaker		22. DATE SIGNED 6. 28. 67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/3/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Robert P. Ware				25a. REC'D BY REGISTRAR JUL 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Nov. 7, 1954

U.S.

Philadelphia, Pa.

Philadelphia, Pa.

Philadelphia, Pa.

NO

Philadelphia, Pa.

Philadelphia, Pa.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07628

07610

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Green Gables, Pasadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Green Gables, Pasadena			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital DOA				d. STREET ADDRESS Rt. 1, Box 94			
3. NAME OF DECEASED (Type or print) First Middle Last WILBUR EDWARD MILLS				4. DATE OF DEATH Month Day Year June 23, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/23	9. AGE (In years last birthday) yrs. 44	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipper				10b. KIND OF BUSINESS OR INDUSTRY Lock Insulator		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Edward T. Mills				14. MOTHER'S MAIDEN NAME Edith Wilder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11				16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Mrs. Edith Priller, same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead in car by sister - no signs of violence						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type)		M.D. Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 6/24/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 26 June 67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR JUN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

ALBVC

2237

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07629

CERTIFICATE OF DEATH

07611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN lb <u>4 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>2300 E. Baltimore St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>P.</u> Last <u>Mislovich</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 6 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>PROKOPIY TKACH</u> <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>TATIANA unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records (CA) PAUL L MISLOVICH</u> <u>2300 E BALTO ST</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>63</u> , to <u>6/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> , 19 <u>67</u> , and that death occurred at <u>1:15M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>6/6/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>	
22d. ADDRESS <u>Crownsville, State Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 9 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL PARK</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>TAYLOR AVE BALTO MD</u>			
24. FUNERAL DIRECTOR <u>THE DIPPEL BROS INC 1800 E LOMBARO ST.</u>				25a. REC'D BY REGISTRAR <u>JUN 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

ES350

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07636

CERTIFICATE OF DEATH

07612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alonzo Middle (none) Last MORRIS				4. DATE OF DEATH Month June Day 8 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/34	9. AGE (In years lost birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Robert A Morris				14. MOTHER'S MAIDEN NAME Emma H.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes			16. SOCIAL SECURITY NO.		17. INFORMANT A. William Morris Address Cooper Rd. Churchton Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary heart failure, Probable pneumonia							INTERVAL BETWEEN ONSET AND DEATH one week years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to June 7, 19 67 , that (I) (x) last saw the deceased alive on June 7, 19 67 , and that death occurred at 1:20 AM M, from causes and on the date stated above.							
22a. SIGNATURE Willard F. Smith				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE/SIGNED 6/8/67	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.				22d. ADDRESS Shady Side, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 10 1967		23c. NAME OF CEMETERY OR CREMATORY Woodfield		23d. LOCATION (City or Town) (County) (State) Lidlesville AA Md.	
24. FUNERAL DIRECTOR Bernard Hardisty				25. RUN BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

05634

1950

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07631

CERTIFICATE OF DEATH

07613

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>920 President St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>920 President St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>R.</u> Last <u>NOLAN</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1904</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Internal Revenue</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>			
13. FATHER'S NAME <u>James R. Nolan</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Theresa Lee</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Eleanor G. Nolan</u> Address <u>#2</u>			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angina pectoris</u> DUE TO (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour _____ a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (as hospital director) attended the deceased from <u>4-5-67</u> , to <u>6-1-67</u> , that (I) (as) <u>not</u> saw the deceased alive on <u>6-8-67</u> and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>Frank M. Shipley</u>			22b. DATE SIGNED <u>6-13-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Frank M. Shipley, M.D.</u>		
22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				
23b. DATE THEREOF <u>6-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) <u>Md.</u>			
23e. FUNERAL DIRECTOR <u>John M. Layla + Sons Annapolis, Md.</u>			25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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200 President St.

Male White

James R. Nolan

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Internal Revenue

1225/9

Margaret Theresa Lee

Eleanor G. Nelson

8-13-67 Ft. Lincoln

FOR STATE
HEALTH DEPT

07632

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07614

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 210 A. Hill Top Lane # 204 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD J. O'BRIEN		4. DATE OF DEATH Month June Day 18 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 28, 1919
9. AGE (In years lost birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rest. mgr.	11. BIRTHPLACE (State or foreign country) MASS
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William T. O'Brien	
14. MOTHER'S MAIDEN NAME Helena		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII	
16. SOCIAL SECURITY NO. many B. O'Brien		17. INFORMANT # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto accident		
20c. TIME OF INJURY Month, Day, Year June 18 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Annapolis, Anne Arundel, Md
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 6/19/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		23. NAME OF CEMETERY OR CREMATORIUM Resurrection	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 22, 1967	23c. LOCATION (City or Town) (County) (State) Clinton, Md	23d. REC'D BY REGISTRAR Charles Judge
24. FUNERAL DIRECTOR W. W. Taltrow 3603 14th St N.W. DC. 20010		25. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

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3352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07633

CERTIFICATE OF DEATH

07615

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Galesville			
3. NAME OF DECEASED (Type or print) First Claude Middle OFFER Last OFFER				4. DATE OF DEATH Month June Day 12 Year 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1882		9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215 039298		17. INFORMANT Jerry Turner Address Galesville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure 1945 4331 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolic to left ventricle DUE TO (c) Ascaris roundworm infection						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/10 , 19 67 , to 6/12 , 19 67 , that (I) (we) last saw the deceased alive on 6/11 , 19 67 , and that death occurred at 6:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE R. Bean				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/13/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 6/14-1967		23c. NAME OF CEMETERY OR CREMATORY Ebenezer		23d. LOCATION (City or Town) (County) (State) Galesville Md	
24. FUNERAL DIRECTOR William Reese				ADDRESS Arundel Md		25a. REG'D BY REGISTRAR JUN 14 1967	
						25b. REGISTRAR'S SIGNATURE J. Charles Jones	

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MINUTE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07634

CERTIFICATE OF DEATH

09060

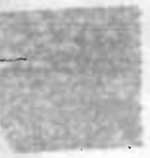
1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3014</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>2318 Fleet Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julian</u> Middle <u>Olejniak</u> Last <u>Olejniak</u>				4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>19 67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/87</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Polish Army</u>		17. INFORMANT <u>Hospital Records, Crownsville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia, congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/9/</u> , 19 <u>67</u> , to <u>6/22/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/22/</u> , 19 <u>67</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>E. Dorkan, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Dorkan, M.D.</u>				22d. ADDRESS <u>Crownsville State Hospital</u>			
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u> </u>		23b. DATE THEREOF <u>7-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>W. Ind. Med. School</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>William Reese H</u>				25a. REC'D BY REGISTRAR <u>JUL 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03834

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, NEW YORK CITY

1910



Handwritten notes and signatures, including a large 'D' and other illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07633

CERTIFICATE OF DEATH

07616

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis, Md</i>		c. LENGTH OF STAY IN 1b <i>3805</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Nebraska</i> b. COUNTY <i>Omaha</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edwin R. Owens</i>		4. DATE OF DEATH Month <i>June</i> Day <i>10</i> Year <i>1967</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>Cauc.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <i>Aug 8 - 1924</i>		9. AGE (In years last birthday) <i>42 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Air Force</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ret-USA7</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Eagle City, Okla.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Roy H. Owens</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN Imogene Lemmon</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>445-16-9262</i>	
17. INFORMANT <i>Fonda Owens</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis obliterans</i> (c) <i>diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs +</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.		22a. SIGNATURE <i>Robert H. Shinsky LCDR (MC) USNR</i>		22b. DATE SIGNED <i>6-11-67</i>		22c. PHYSICIAN'S NAME (Type) <i>Annapolis, MD.</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-16-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Highland Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Lawton Okla.</i>		25a. REC'D BY REGISTRAR <i>JUN 14 1967</i>	
24. FUNERAL DIRECTOR <i>John M. Sayle & Sons Annapolis, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME <i>Charles Judge</i>		25d. REGISTRAR'S ADDRESS		25e. REGISTRAR'S PHONE	

MEDICAL CERTIFICATION

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Dr. H. J. ...

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Det. 10. 1/2 lb. + 2 lb. 1/2 lb.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07636

CERTIFICATE OF DEATH

07617

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>		d. STREET ADDRESS <u>Rt 1 Box 420</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Ellen</u> Last <u>PERRY</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan 24, 1888</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mayfield Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Southerland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Clyde Sturgill</u>		Address <u>Davidsonville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Endotoxin shock</u> <u>585X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gram negative septicemia</u> DUE TO (c) <u>Acute cholecystitis with rupture</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>6 hours</u> <u>72 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Aortic stenosis, Aortic abdominal aneurysm, Diabetes mellitus, Degenerative arthritis.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1967</u> , to <u>June 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1967</u> , and that death occurred at <u>12:30</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Kinzer</u>		22b. DATE SIGNED <u>June 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>		22d. ADDRESS <u>Lyons Prof. Bldg. 16 Murray Ave, Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>June 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Flatspur Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Dickinson Co., Va.</u>
24. FUNERAL DIRECTOR <u>Beverley L. Hopping</u> <u>HOPPING FUNERAL HOME - Annapolis, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 15 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07637

CERTIFICATE OF DEATH

07618

1. PLACE OF DEATH a. COUNTY AA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY in 1b 23 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS 715 Holly Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle S. Last Phillips		4. DATE OF DEATH Month 6 Day 12 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-90
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months 12 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker helper retired		10b. KIND OF BUSINESS OR INDUSTRY B.O.R.R	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. R. Phillips		14. MOTHER'S MAIDEN NAME Theresa Bertha ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT John Phillips 2919 Delaware Ave - 21227		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concurrence of the Kidney DUE TO 180x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia Severe - Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:00 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/21/66 , 19 67 , to 6/12/67 , 19 67 , that (I) (we) last saw the deceased alive on 6/11/67 , 19 67 , and that death occurred at 6:35 M, from causes and on the date stated above.			
22a. SIGNATURE J. B. Rammer		22b. DATE SIGNED 6/12/67	
22c. PHYSICIAN'S NAME (Type) J. B. RAMMER		22d. ADDRESS 3927 ANNAPOLIS RD Balto 27 Md 1672 NORTHBOURNE RD Balto 12 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/15/67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven	23d. LOCATION (City or Town) (County) (State) Glen Burnie Md.
24. FUNERAL DIRECTOR John J. Cowan & Son, Inc. 901 Hollins St.		25a. REC'D BY REGISTRAR JUN 14 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

100-100000

UNITED STATES DEPARTMENT OF JUSTICE

100-100000

TO THE HONORABLE ATTORNEY GENERAL
FROM THE DIRECTOR, FBI
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including a subject line, a date, and a body of text. Some words like "TO THE HONORABLE ATTORNEY GENERAL" and "FROM THE DIRECTOR, FBI" are faintly visible at the top.]

RECEIVED
FBI
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

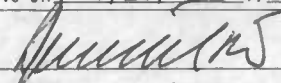
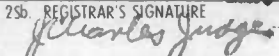
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07638

CERTIFICATE OF DEATH

07619

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 2307 Eastern Ave. # 24			
3. NAME OF DECEASED (Type or print) First George Middle Webster Last Pirie				4. DATE OF DEATH Month 6 Day 16 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/93		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Stand. Oil Co.		11. BIRTHPLACE (County & State, or foreign country) Lynn, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Pirie				14. MOTHER'S MAIDEN NAME Isabella D. ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-14-5108		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/13 , 19 65 , to 6/16 , 19 67 , that (I) (we) last saw the deceased alive on 6/16/1967 , and that death occurred at 7:55 M, from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 6/16/67		22c. PHYSICIAN'S NAME (Type) L. Benedict M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City or Town) (County) (State) 5712 O'Donnell St. Balto., Md.	
24. FUNERAL DIRECTOR Charles S. Ziller		25a. REC'D BY REGISTRAR 201 S. Conowing St. Baltimore, Md.		25b. REGISTRAR'S SIGNATURE 		25c. DATE JUN 20 1967	

77033

Home Address

Chromwell

Chromwell State Hospital

Barrow - Hobart

Elia

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Notified

Stann. Oil Co.

John, Texas

George White

Isabella D.

21-1-1908

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Notified

Stann. Oil Co.

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Isabella D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07633

CERTIFICATE OF DEATH

07620

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galesville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Galesville St., Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Poble</u>				4. DATE OF DEATH Month Day Year <u>6 21 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/81</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>G Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>FRANCE</u>	
13. FATHER'S NAME <u>Jouslin Crompes</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome with</u> <u>4201</u> DUE TO <u>Psychotic reaction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic brain syndrome with psychotic reaction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/12/</u> , 1967, to <u>6/21/</u> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6/21/</u> 1967, and that death occurred at <u>8:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>L. Benedict</u>				22b. DATE SIGNED <u>6/21/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis AA MD</u>	
24. FUNERAL DIRECTOR <u>Hardisty Funeral Home, Galesville, MD</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

07633

CERTIFICATE OF DEATH

1919

[Faint, mostly illegible text and lines forming a form structure, likely a death certificate. The text is mirrored and appears to be bleed-through from the reverse side of the page.]

of 10/10/19

1919

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07621

1. PLACE OF DEATH o. COUNTY <u>PACO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12 - 13-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North ARUNDEL Hospital</u>				d. STREET ADDRESS <u>216 Rodgers Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>T.</u> Last <u>Poppe</u>				4. DATE OF DEATH Month <u>6</u> Day <u>✓</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-91</u>	9. AGE (In years lost birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RAK FORD, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LUCIUS A. TROW BRIDGE</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE COBB</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>329-03-0622</u>		17. INFORMANT <u>MRS. CAROLINE F. HALES</u> Address <u>SEVERNA PARK 117 BOONE TRAIL RD. MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8254 Multiple Myeloma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>20 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car accident - Highway</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> a.m. <u>4/2</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>PACO MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>		EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. <u>✓</u>		22. DATE SIGNED <u>6-2-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		23b. DATE THEREOF <u>6/7/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Evanston, Ill.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore, Md. 21212</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100000

100000

THE UNIVERSITY OF CHICAGO

CHICAGO, ILLINOIS

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #12 Film #G390 7/6/67

CERTIFICATE OF DEATH

07641

07622

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>5 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles County</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Cobb Island Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Duncan</u> Middle <u>Power</u> Last <u>Power</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>19 67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6/11/85</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-01-3445</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>H200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Failure Generalized</u> DUE TO <u>arteriosclerosis</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to generalized arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>67</u> , to <u>6/27</u> , 19 <u>67</u> , that (I) (we) lost the deceased on <u>6/27</u> , 19 <u>67</u> , and that death occurred on <u>6:35</u> P, from causes and on the date stated above.							
22a. SIGNATURE <u>L. Benedict</u>				22b. DATE SIGNED <u>6/28/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>	
22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>6-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		23d. LOCATION (City or Town) (County) (State) <u>Culpeper</u> <u>VA</u>		24. FUNERAL DIRECTOR <u>Charles Judge</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 30 1967</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1934

1934

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Cause of Death		Place of Death	
Time of Death		Signature of Physician	
Signature of Registrar		Signature of Coroner	

Attest: _____
Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07642

CERTIFICATE OF DEATH

07623

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARLEY STATION			d. STREET ADDRESS MARLEY STATION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNE Middle MARTHA Last PUMPHREY			4. DATE OF DEATH Month JUNE Day 1 Year 19 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 OCT. 1883	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) KENT CO. MARYLAND	
12. CITIZEN OF WHAT COUNTRY? US			13. FATHER'S NAME RICHARD B. WILLSON		
14. MOTHER'S MAIDEN NAME ELLA A. Mac Adam			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Anne L. Gary - Glen Burnie, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA with right hemiplegia DUE TO (b) Generalized arteriosclerosis DUE TO (c) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 2/22/1963 , to 6/1/1967 , that (I) (we) last saw the deceased alive on 6/1/1967 , and that death occurred at 3:45 AM , from causes and on the date stated above.					
22a. SIGNATURE Edmond I. Moushabeck		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/67	
22c. PHYSICIAN'S NAME (Type) EDMOND I. MOUSHABECK		22d. ADDRESS 510 Harbor Station Road, Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5 June 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn, Maryland	
24. FUNERAL DIRECTOR Eugene B. Fleming		• ADDRESS Singleton Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE JUN 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

2250

1014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07643					07624				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Anne Arundel Co</u> MARYLAND					a. STATE <u>MD.</u> b. COUNTY <u>H.A.Co</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u>				
c. LENGTH OF STAY IN 1b <u>4 years</u>					d. STREET ADDRESS <u>47 St Andrews Rd.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>47 St Andrews Rd.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Marion Anna Puszycki</u>					4. DATE OF DEATH <u>6-1-67</u> 19 <u>67</u>				
5. SEX <u>F</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Dec 7, 1892</u> 74 yrs.				
9. AGE (In years last birthday) <u>74</u>					10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Marion Wisniewski</u>					14. MOTHER'S MAIDEN NAME <u>Estelle</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>no</u>				
17. INFORMANT <u>John J. Dawson - Above</u>					Address <u>above</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>									
4201 DUE TO <u>A.C.V.D.</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Sen art</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u>19</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>67</u> , to <u>1967</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-31-67</u> 19 <u>67</u> , and that death occurred at <u>1P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert R. Hahn</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22b. DATE SIGNED <u>6/6/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u> 22d. ADDRESS <u>P.O. Box 73 Severna Park</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE THEREOF <u>6-5-67</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>									
23d. LOCATION (City, town or county) (State) <u>Bethesda Md</u>									
24. FUNERAL DIRECTOR <u>Severna Park Funeral Home, Severna Park, Md.</u> ADDRESS									
25a. REC'D BY REGISTRAR <u>JUN 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

03025

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1911

2

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07644

07625

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>W. O. A. General</u>		d. STREET ADDRESS <u>25 Moncument St</u>	
3. NAME OF DECEASED (Type or print) <u>Leroy Randolph</u>		4. DATE OF DEATH <u>6 11 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1945</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Randolph</u>		14. MOTHER'S MAIDEN NAME <u>Flora Cowans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>238-74-7152</u>	
17. INFORMANT <u>James Randolph</u>		Address <u>Annapolis, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9298</u> <u>Striking</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Struck</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While Swimming Back Creek</u>	
20c. TIME OF INJURY Month, Day, Year <u>6/11 1967</u> Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> ot work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back Creek</u>		20f. (City or town) <u>Atles</u> (County) <u>RS</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>6-11-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-16-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Randolph</u>	23d. LOCATION (City or Town) <u>Bolivia</u> (County) <u>MD</u> (State) <u>MD</u>
24. FUNERAL DIRECTOR <u>William Reese</u>		25. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1885

1885

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1885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 6390 7/18/67 vk

07645

CERTIFICATE OF DEATH

07626

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Baltimore Md.)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Baltimore Md.)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>513 East 23rd</u> <u>Cooper Convalescent Home</u> <u>406 Morris Hill Ave. Glen Burnie</u>	
3. NAME OF DECEASED (Type or print) First <u>Booker</u> Middle <u>Rayfield</u> Last <u>Rayfield</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6/17/12</u>
9. AGE (In years <u>55</u> birthday yrs.)		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George Rayfield</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Douglass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Mary Rayfield</u>		Address <u>513 E 23rd St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>6-28</u> , 19 <u>67</u> , to <u>6-29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>6-28</u> , 19 <u>67</u> , and that death occurred at <u>12:15</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Ignas Saulynas</u>		22b. DATE SIGNED <u>6-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>IGNAS SAULYNAS</u>		22d. ADDRESS <u>319 Old Annapolis Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetry</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W North Ave</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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RECEIVED BY TRANSMISSION

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RECEIVED BY TRANSMISSION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07646

CERTIFICATE OF DEATH

07627

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		d. STREET ADDRESS <u>506 W. Ann Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Raymond</u> Last <u>Lucas</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Jan 1900</u> 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>67</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard F. Lucas</u>		14. MOTHER'S MARDEN NAME <u>Alice Morrissey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>082-20-1135-A</u>	17. INFORMANT <u>Daughter</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 444x DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u> <u>20 years +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>June 14, 1967</u> to <u>June 14, 1967</u> , that (1) (we) last saw the deceased alive on <u>—</u> 19 <u>—</u> , and that death occurred at <u>10:30 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>David Abramson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>David Abramson</u>		22d. ADDRESS <u>707 Balt. Annap Bld Green</u> <u>Burnie</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>June 17, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery,</u>	23d. LOCATION (City or Town) (County) (State) <u>Lynbrook, New York 11563</u>
24. FUNERAL DIRECTOR <u>HAROLD S. Wade, LAUREL M. Fyfe</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 15 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

THE UNIVERSITY OF CHICAGO PRESS

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FS77-100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07647

07628

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A - No 16 ARUNDEL -</u>		d. STREET ADDRESS <u>Box 418 - Rt 175</u>	
3. NAME OF DECEASED (Type or print) <u>Takie J Riggs</u>		4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-93</u>
9. AGE (In years last birthday) <u>23</u> yrs.		10. IF UNDER 1 YEAR Months <u>29</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Berkeley County, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Leona Pearl Riggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Arlean Riggs- Jessup, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>8254</u> IMMEDIATE CAUSE (a) <u>Muscle & ligaments</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Short</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident -</u>	
20c. TIME OF INJURY Month, Day, Year <u>6/29 1967</u> Hour <u>6</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>AA Co MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>6-29-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Ganotown Berkeley W.Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Central E.U.B. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Ganotown Berkeley W.Va.</u>
24. FUNERAL DIRECTOR <u>H. K. Brown</u> <u>Brown Funeral Home Martinsburg, W.Va.</u>		25a. REC'D BY REGISTRAR <u>JUL 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

07657

Laborer

Construction

Herkeley County, Va.

Leonard, Fred

Herkeley County, Va.

Herkeley County, Va.

Herkeley County, Va.

Herkeley County, Va.

Herkeley County, Va.

Herkeley County, Va.

Herkeley County, Va.

Herkeley County, Va.

Herkeley County, Va.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07648

07629

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 29 Decatur Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Amelia Middle Emma Last RITTERBUSH				4. DATE OF DEATH Month June Day 6 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1894	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) Woodhawn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES WOODMAN				14. MOTHER'S MAIDEN NAME MARY M. MAHONEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT HENRY J. RITTERBUSH # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastasis to pleura, lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) shin, bone, liver & brain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from Apr - , 19 66 to June 6, 19 67 , that (I) last saw the deceased alive on June 6, 19 67 , and that death occurred at M , from causes and on the date stated above.							
22a. SIGNATURE F.M. SHIPLEY			ATTENDING MED. DIR. <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 8:10 PM		22b. DATE SIGNED 6-8-67		
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY			22d. ADDRESS 121 Cathedral St., Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIED	23b. DATE THEREOF 6-9-67	23c. NAME OF CEMETERY OR CREMATORY Maple Grove	23d. LOCATION (City or Town) (County) (State) Kew City N.Y.				
24. FUNERAL DIRECTOR John M. Layla & Sons Annapolis, Md.			25a. REC'D BY REGISTRAR DATE JUN 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF DEBIT

1964

Account Name: [illegible]
Address: [illegible]
City: [illegible]
State: [illegible]
Zip: [illegible]

Account Number: [illegible]

Account Type: [illegible]

Account Balance: [illegible]

Account Holder: [illegible]

Charles [illegible]

Henry J. Pittsbaugh #2

[Large block of illegible text, likely a list of transactions or account details]

Page 1 of 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07649

07630

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilson Town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilson Town</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James B Rollins</u>		4. DATE OF DEATH <u>6</u> <u>4</u> <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-1894</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Rollins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ann Rollins</u>		Address <u>Wilson Town</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4200</u> IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arterio sclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>10 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>46</u> , to <u>June 4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>June 2</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Edward G. Skerritt</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edward G. Skerritt M.D.</u>		22d. ADDRESS <u>Gambria, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>6-7-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forbes</u>	23d. LOCATION (City or town) (County) (State) <u>Adenton Md.</u>
24. FUNERAL DIRECTOR <u>William Reese # Anna M.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE CENSUS
U.S. DEPARTMENT OF COMMERCE
WASHINGTON, D.C.

1900

1900

Handwritten notes and signatures, including a large signature at the bottom left and a date "June 1900" at the bottom right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G389 6/7/67 kkk

07650

CERTIFICATE OF DEATH

07631

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN TB <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>			d. STREET ADDRESS <u>1030 Sterling Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Sampson</u>			4. DATE OF DEATH Month Day Year <u>6/1/1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/96</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>1/19/67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WHOLESALE GROCERY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chadburn N.C.</u>	
13. FATHER'S NAME <u>Unknown JACK GOWAN</u>			14. MOTHER'S MAIDEN NAME <u>Emma Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-07-4737</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Cardio vascular disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/19/67</u> , 19 <u>67</u> , to <u>6/1/1967</u> , that (I) (we) last saw the deceased alive on <u>6/1/1967</u> and that death occurred at <u>1:25M</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>			22b. DATE SIGNED <u>6/1/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>
22d. ADDRESS <u>Crownsville State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>6-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Not known</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>					
24. FUNERAL DIRECTOR <u>Trans Service of Hgtz 236 W. B. Linn</u>			25. REC'D BY REGISTRAR DATE <u>JUN 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

1000

1000



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07651

07632

1. NAME OF DECEASED
(Type or Print)

AUGUSTUS MILBY SCHAUBE

2. DATE AND HOUR OF DEATH

JUNE 4, 1967

3. PLACE OF DEATH IN BALTIMORE-MARYLAND

ANNE ARUNDEL COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

BROOKLYN PARK 25

113 W. HILLTOP RD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD. ANNE ARUNDEL

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BROOKLYN PARK, 25

D. STREET ADDRESS (If rural, give location)

113 HILLTOP ROAD

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

FEB 11, 1906

9. AGE (In years
lost birthday)

61

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

CHARLES E. SCHAUBE

14. MOTHER'S MAIDEN NAME

ALBERTA MILBY

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

MRS AUGUSTUS SCHAUBE, 113 W. HILLTOP
BROOKLYN PARK

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Carcinoma Lung

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

1 year

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19
that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date,
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

6-7-67

23D. ADDRESS

M.D.

MED. CNTR. HAMMOND'S LANE
BALTO. 25 MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

JUNE 8, 1967

24C. NAME of CEMETERY or CREMATORY

GREENSBORO

24D. LOCATION

(City, town, or county)

(State)

GREENSBORO, MD.

VR A15 (4)
25M 1/67

25A. DATE REC'D BY HEALTH DEPT.
JUN 15 1967

25B. NAME OF REGISTRAR

Charles Judge

25C. FUNERAL DIRECTOR

CHARLES MOORE DENTON, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the State Department of Health.

SECRET

12077

OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301-1000
ATTENTION: THE SECRETARY OF DEFENSE
OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301-1000

SECRET

SECRET

SECRET

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07652

07633

1. PLACE OF DEATH a. COUNTY <u>B.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. LENGTH OF STAY IN 1b <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		d. STREET ADDRESS <u>1st AVE - E. Ferndale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.H. - North. Arundel.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>G.</u> Last <u>SCHLESINGER</u>				4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>19 67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-93</u>	9. AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Schlesinger</u>				14. MOTHER'S MAIDEN NAME <u>Emma</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-2612</u>		17. INFORMANT Address <u>8 First Ave</u> <u>Mrs. Clara M. Schlesinger, E. Ferndale, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linbrook St.</u>		EXAMINER'S NAME (Type) <u>E. Linbrook St.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <u>6-7-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-10-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>				25a. REC'D BY REGISTRAR <u>JUN 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

806

806

1,111,111

1,111,111

806

806

15 (4)
9/59

CERTIFICATE OF DEATH

07653

07634

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1607 Saunders Way, Glen Burnie Md</u>		d. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>Ernest Andreew Schneider</u>		4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/75</u>
9. AGE (In years last birthday) <u>92</u>		10. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John C. Schneider</u>		14. MOTHER'S MAIDEN NAME <u>MARY L. Zelt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>366-16-9546</u>	
17. INFORMANT <u>K. G. Schneider</u>		Address <u>50 Whitlock Dr. Severn Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Circulatory Collapse</u> DUE TO (c) <u>Generalized Carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mths</u> <u>10 mths</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Hour a. m. <u>-</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> 19 <u>62</u> to <u>4/12</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/28</u> 19 <u>67</u> , and that death occurred at <u>3P</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>H. W. Prichard</u>		22b. DATE SIGNED <u>6/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. W. PRICHARD MD</u>		22d. ADDRESS <u>Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-1-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Pk.</u>		23d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Evans</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07654

CERTIFICATE OF DEATH

07635

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>80 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>932 West Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Brown</u> Last <u>Scible</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> , Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel C. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William T. Scible</u>		14. MOTHER'S MAIDEN NAME <u>Emma Melinda Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-50-9260</u>	
17. INFORMANT <u>Mary E. Scible (sister)</u> Address <u>same address as decedent</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, aspirational</u> 1530 DUE TO Cancer of cecum, suspected (b) DUE TO (c) <u>6 6 - - - - -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis (old) with left hemiparesis, Anasarca</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 24, 1967</u> , to <u>June 25, 1967</u> that (I) (we) last saw the deceased alive on <u>June 25, 1967</u> , and that death occurred at <u>2:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Kinzer</u>		22b. DATE SIGNED <u>June 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>		22d. ADDRESS <u>16 Murray Av., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>6-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. G. L. & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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Get it?

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 18-21 Film 389
6-14-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07636

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 1018 Whatcoat Street			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLIE (Charles) SCOTT				4. DATE OF DEATH Month Day Year June 5, 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1915		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Roanoke Rapids, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Scott				14. MOTHER'S MAIDEN NAME Josephine Banks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Emma Suber		Address 1018 Whatcoat St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation due to inhalation of sewer gas 894.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in manhole					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:15 a.m. June 5 19 67		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) -- Anne Arundel Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 6/6/67	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-10-67	23c. NAME OF CEMETERY OR CREMATORY Weldon Cemetery		23d. LOCATION (City or Town) (County) (State) Weldon N.C.			
24. FUNERAL DIRECTOR Mocton & Dyck F.H.				ADDRESS 1701 Laurens St.		25a. REC'D BY REGISTRAR 1967	

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(Continued)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07656

CERTIFICATE OF DEATH

07637

1. PLACE OF DEATH a. COUNTY <u>A.A. CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AACO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>12-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>		d. STREET ADDRESS <u>Annapolis Terrace Hotel</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>D</u> Last <u>Seery</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-13</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>53</u> Days <u>53</u> Hours <u>53</u> Min. <u>53</u>	IF UNDER 24 HRS. Months <u>53</u> Days <u>53</u> Hours <u>53</u> Min. <u>53</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Virginia</u>	
13. FATHER'S NAME <u>Marvin E. Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Jeanette Welch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-22-9726</u>	
17. INFORMANT <u>Mr. Spencer W. Seery, Jr.</u>		Address <u>same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma colon</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>6 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 27</u> , 19 <u>67</u> , to <u>6-18-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-17-67</u> , 19 <u>67</u> , and that death occurred at <u>7A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>E. Linhardt</u>		22b. DATE SIGNED <u>6/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Linhardt</u>		22d. ADDRESS <u>Annapolis - MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/21/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. F. Tichner & Son</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07657

CERTIFICATE OF DEATH

07638

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>527 w. Cedar Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Micheal</u> Last <u>Shea Sr.</u>				4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/12</u>		9. AGE (In years lost birthday) yrs. <u>55</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Shea</u>				14. MOTHER'S MAIDEN NAME <u>Leona Frey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-9010</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiopneumonia</u> <u>353.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Status epilepticus</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to convulsive disorder</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/14/1967</u> , to <u>6/16/1967</u> , that (I) (we) last saw the deceased alive on <u>6/16/1967</u> , and that death occurred at <u>2:40 M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>L. Benedict</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.O. <u> </u>		22b. DATE SIGNED <u>6/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>				22d. ADDRESS <u>Crownsville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Anne Arundel Co. Md.</u>	
24. FUNERAL DIRECTOR <u>McCully Funeral Home</u>				ADDRESS <u>237 Patapsco Ave.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 19 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07658

CERTIFICATE OF DEATH

07639

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 405 Maple Lane N/W				d. STREET ADDRESS 405 Maple Lane N/W				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First G.		Middle SHUTE		4. DATE OF DEATH Month June Day 11 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 Feb. 1902		9. AGE (In years lost birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY Local #438		11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Clarence Shute				14. MOTHER'S MAIDEN NAME Mary Turner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 050-03-401 A		17. INFORMANT Address Clarence E. Shute (brother)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-2-64 , 19 64 , to 6-11 , 19 67 , that (I) (we) last saw the deceased alive on 6-11 , 19 67 , and that death occurred at 10:55 AM , from causes and on the date stated above.									
22a. SIGNATURE Robert Dabolins						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-13-67	
22c. PHYSICIAN'S NAME (Type) Robert Dabolins						22d. ADDRESS 400 Crain Hwy. N/W, Glen Burnie			
23a. BURIAL, CREMATION, BURIAL (city)		23b. DATE THEREOF 6/14/67		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Pk.			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Singleton Funeral Home/ Glen Burnie, Md.						25a. REC'D. BY REGISTRAR DATE JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07659

07641

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY in lb Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS Rt. 3, Box 44 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Abraham Ridgley SMITH		4. DATE OF DEATH Month Day Year June 30 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY self Employed	
11. BIRTHPLACE (County & State, or foreign country) A.A.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lizzie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph C. Smith-box 32-Rt.3 Annapolis, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-29-67 19__, to 6-30-67 19__, that (I) (we) last saw the deceased alive on 6-29-67 19__, and that death occurred at 5:25 A.M. from causes and on the date stated above.			
22a. SIGNATURE Ann T. Allen		22b. DATE SIGNED 6-30-67	
22c. PHYSICIAN'S NAME (Type) Ann T. Allen		22d. ADDRESS 621 Colthorne St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 3-67	
23c. NAME OF CEMETERY OR CREMATORY St. Anne's		23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR C.E. Hicks III		25a. REC'D BY REGISTRAR JUL 6 1967	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

2033

CERTIFICATE OF DEATH

2033

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Cause of death

6. Place of death

7. Signature of physician

8. Signature of registrar

9. Date of registration

10. Signature of informant

11. Signature of witness

12. Signature of registrar

13. Signature of physician

14. Signature of informant

15. Signature of witness

16. Signature of registrar

17. Signature of physician

18. Signature of informant

19. Signature of registrar

20. Signature of witness

21. Signature of physician

2033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>AMN CRENSHAW CO.</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>PASADENA</i> c. LENGTH OF STAY IN 1b <i>MD.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Rt 5 - Box 54</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>P.A. Co.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sensen Knoll (Pasadena)</i> d. STREET ADDRESS <i>Rt 5 - Box 54</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Virginia Blane Snyder</i>		First		Middle		Last		4. DATE OF DEATH <i>6-15-67</i>		Day Month Year <i>19</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>24 March 1902</i>		9. AGE (in years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Ill. Tenn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Robert Scott</i>				14. MOTHER'S MAIDEN NAME <i>EVA R Rowe</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>219-05-1215</i>		17. INFORMANT <i>William R. Snyder - San #2</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Infection</i> DUE TO <i>Massive Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Brain Stem involvement</i> DUE TO <i>Adenocarcinoma of ovary</i> (c) <i>Adenocarcinoma of ovary</i>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19 <i>67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-12-67</i> , and that death occurred at <i>2:55 PM</i> from the causes and on the date stated above.													
22a. SIGNATURE <i>Robert B. HAHN</i>				M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/15/67</i>					
22c. PHYSICIAN'S NAME (Type) <i>Robert B. HAHN</i>				22d. ADDRESS <i>Severna Park Rd</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/17/1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Louisa Park Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore Md.</i>					
24. FUNERAL DIRECTOR <i>Robert R. HAHN</i>				ADDRESS <i>Singleton Funeral Home / Clonbury</i>		25a. REC'D BY REGISTRAR <i>JUN 19 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

DEPARTMENT OF HEALTH

Ten

1901

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07661

CERTIFICATE OF DEATH

07643

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover				c. LENGTH OF STAY IN 1b 56 Yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box #16, Hanover and Ridge Roads				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First MARY Middle SROKA Last SROKA				4. DATE OF DEATH Month June Day 21 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 17, 1890	
9. AGE (In years last birthday) 76 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME (unknown) Domchenski		14. MOTHER'S MAIDEN NAME Rose (unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220/44/8292		17. INFORMANT Mrs. Margaret Grabbowski Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State).	
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 63 , to June , 19 67 , that (I) (we) lost the deceased alive on June , 19 67 , and that death occurred at 7:22 P.M., from causes on and on the date stated above.							
22a. SIGNATURE Hilary T. O'Herlihy				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-22-67	
22c. PHYSICIAN'S NAME (Type) Hilary T. O'Herlihy M.D.				22d. ADDRESS # 5 Central Ave. Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 26, 67		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City or Town) (County) (State) German Hill Rd. Balt. Co.	
24. FUNERAL DIRECTOR R.V. SINGLETON				ADDRESS GLEN BURNIE, MD.		25a. REC'D BY REGISTRAR JUN 26 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07662

CERTIFICATE OF DEATH

07644

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) City - Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 602 Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Everette Henry STERLING				4. DATE OF DEATH Month Day Year June 10, 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1897		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sea Food Packing		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Noah Sterling				14. MOTHER'S MAIDEN NAME Dora Hughes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address William Sterling, Cambridge, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis essential DUE TO Diuretic (c)						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-2-67 , 19 67 , to 6-10-67 , 19 67 , that (I) (we) last saw the deceased alive on June 10, 1967 , and that death occurred at 10:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-12-67	
22c. PHYSICIAN'S NAME (Type) A T ALLEN				22d. ADDRESS 62 CATHEDRAL ST			
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem-Burial		23b. DATE THEREOF 6/14/1967		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR [Signature]				ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 1967	
				25b. REGISTRAR'S SIGNATURE [Signature]			

02603

RECORD OF DEATH

100-10000

John Arundel

Maryland

John Arundel

John Arundel

City - Annapolis

John Arundel General Hospital

602 Second Street

Everette

Henry

STELLING

June 10

October 2, 1897

Wagon

Maryland

June 10

June 10

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07663

CERTIFICATE OF DEATH

07645

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE			c. LENGTH OF STAY IN 1b 8 Hrs 10 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODENTON		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS 514 BRUCE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NATHANIEL HENRY Middle Last NOT NAMED TABOR				4. DATE OF DEATH Month JUNE Day 12 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 JUNE 1967		9. AGE (In years last birthday) yrs. 12	IF UNDER 1 YEAR Months 8 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gerald E. Tabor				14. MOTHER'S MAIDEN NAME Vivian I. Farrand			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Ft Geo G. Meade, Md. Medical Record, Kimbrough Army Hosp			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia Cardiac Arrest 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from 12 June , 19 67 , to 12 June , 19 67 , that (he) (we) last saw the deceased alive on 12 June , 19 67 , and that death occurred at 8:45 M. from causes and on the date stated above.							
22a. SIGNATURE Capt Felix A. Conte				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12 JUNE 1967	
22c. PHYSICIAN'S NAME (Type) FELIX A. CONTE, CPT, MC				22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF June 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Carver Mem. Cemetery, Rt #11, Laurel, Maryland		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Harold C. Wadley, Laurel, Md.				25a. REC'D BY REGISTRAR DATE JUN 15 1967		25b. REGISTRAR'S SIGNATURE F. J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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2503

CERTIFICATE OF ANALYSIS

Name of Sample		Date of Analysis	
Description of Sample		Name of Analyst	
Amount of Sample		Reference	
Method of Analysis		Result	
Remarks		Signature of Analyst	
Name of Owner		Name of Inspector	
Address of Owner		Address of Inspector	
City of Owner		City of Inspector	
State of Owner		State of Inspector	
Country of Owner		Country of Inspector	
Name of Agent		Name of Agent	
Address of Agent		Address of Agent	
City of Agent		City of Agent	
State of Agent		State of Agent	
Country of Agent		Country of Agent	

ANALYST'S SIGNATURE: _____

INSPECTOR'S SIGNATURE: _____

AGENT'S SIGNATURE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07664

CERTIFICATE OF DEATH

07646

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN TB 4 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. STREET ADDRESS 3714 - Gallatin St.			
3. NAME OF DECEASED (Type or print) David Teg				4. DATE OF DEATH June 21 19 67			
5. SEX male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH july 9, 1880	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk & Cash Div.-U.S.Trea				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Johannes Teg				14. MOTHER'S MAIDEN NAME Sarah K. Larson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If yes give war or dates of service) No -				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Ralph Teg - N.E., Wash., D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, aspirational 334X DUE TO Bulbar palsy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerosis, cerebral (c)				INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years ? - years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None known				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from June 16, 1967 to June 21, 1967 , that (I) (we) last saw the deceased alive on June 21, 1967 , and that death occurred at 6:45 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Charles W. Kinzer</i>				22b. DATE SIGNED June 21, 1967		22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.	
22d. ADDRESS 16 Murray Ave, Annapolis, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25a. REC'D BY REGISTRAR DATE JUN 26 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1000

MINISTRY OF DEFENSE

23000

Blank page with faint, illegible text and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07665

CERTIFICATE OF DEATH

07647

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-GLEN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-BALTIMORE # 25	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL		d. STREET ADDRESS 407 WAVERLY AVE.	
3. NAME OF DECEASED (Type or print) NORMA TRAVERS		4. DATE OF DEATH Month JUNE Day 6 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15, 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 19 Days 67 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H Hardesty		14. MOTHER'S MAIDEN NAME Sarah E Howard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Hypertensive Cerebral Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemic (c) Ischemic		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia bilobular		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1 (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/3 , 19 67 , to 6/3 , 19 67 , that (I) (we) last saw the deceased alive on 6/3 , 19 67 and that death occurred at 7:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Edgar Freely		22b. DATE SIGNED 6/6/67	
22c. PHYSICIAN'S NAME (Type) Edgar Freely		22d. ADDRESS 1113 Odessa Rd. Odessa	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE THEREOF 6/10/67	
23c. NAME OF CEMETERY OR CREMATORY Friendship Meth Cem		23d. LOCATION (City or Town) (County) (State) Friendship Md	
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225		25a. REC'D BY REGISTRAR DNS JUN 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

3333

UNITED STATES

2000

James H. Brown

William H. Brown

UNITED STATES

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07666

CERTIFICATE OF DEATH

09097

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>30.4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>48 Market Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hugo</u> Middle <u>J.</u> Last <u>Triplett</u>				4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/04</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rullmant and Wilson</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hugh Triplett</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Ridgeley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>18-19 PFC</u>		16. SOCIAL SECURITY NO. <u>213-05-8114</u>		17. INFORMANT <u>Hospital Records</u> Address <u>—</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Pneumonia</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcoholic addiction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>		
21. I certify that (I) (this hospital) attended the deceased from <u>5/27/1967</u> , to <u>6/18/1967</u> , that (I) (we) last saw the deceased alive on <u>6/18/1967</u> , and that death occurred at <u>3:35 P</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>6/19/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Alphonsas Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodstock, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tietman & Sons</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1200

RECORD OF DEATH

1200

2

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07667

CERTIFICATE OF DEATH

07648

1. PLACE OF DEATH <u>ANNE ARUNDEL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY <u>Crownsville state hospital</u> MARYLAND				a. STATE <u>210 W chase st</u> b. COUNTY <u>Baltimore Maryland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<u>Crownsville Maryland since 9-23-48</u>				<u>Baltimore Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
<u>Crownsville state hospital</u>				<u>210 W. chase st</u>			
3. NAME OF DECEASED (Type or print) <u>GILES, E. VIRGIE</u>				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/1894</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>brother and sister in law (Paul Jough) of Prince Georges St</u>		Address <u>1822 N Mause St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7824</u> <u>Cards - respiratory failure</u> DUE TO (b) <u>2 weeks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 weeks</u> DUE TO (c) <u>2 weeks</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-23, 1948</u> , to <u>6-30, 1967</u> , that (we) last saw the deceased alive on <u>6/30/1967</u> , and that death occurred at <u>8:30 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>H. Zinnieden</u>				22b. DATE SIGNED <u>7/11/67</u>		22c. PHYSICIAN'S NAME (Type) <u>H.D. ATTENDING M.D. PHYS.</u> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS <u>CROWNVILLE ST. HOOP</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>7/5/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MA A. O. D. P.</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR <u>Morgan Pittman</u>				25a. REC'D BY REGISTRAR <u>JUL 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100-100000

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE OF NEW YORK

CERTIFICATE OF DEATH

2000

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07668

07649

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Abbott Last WAINWRIGHT		4. DATE OF DEATH Month June Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Underwriter		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wm. S. Wainwright		14. MOTHER'S MAIDEN NAME Beulah Beauchamp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Charlotte Wainwright - Blum		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 6/28 , 19 67 , to 6/29 , 19 67 , that (I) (we) saw the deceased alive on 6/29 , 19 67 , and that death occurred at 5:15 AM from causes and on the date stated above.			
22a. SIGNATURE General Church		22b. DATE SIGNED 6/30/67	
22c. PHYSICIAN'S NAME (Type) General Church		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Severna Park		23d. LOCATION (City or Town) (County) (State) Severna Park, Md.	
24. FUNERAL DIRECTOR Robert S. Barranco		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 3 1967	

County of _____

Know all men by these presents, that _____ of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ in hand paid by _____ the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____

TO HAVE AND TO HOLD unto the said _____ heirs and assigns forever.

And the said _____ do hereby certify that the foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of _____ State of Texas.

Witness my hand and seal of office this _____ day of _____ A.D. 19____.

 County Clerk

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11, 12, 13 & 14 Film #G390 7/3/67 pc

07663

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07650

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ADCO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ADCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT GEORGE G. MEADE</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cumtongh Henry Hospital</u>		d. STREET ADDRESS <u>Box 319 - Jarrettsville</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>F</u> Last <u>Walton</u>		4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hicks</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Crogan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>4344</u> DUE TO (c) <u>stating the underlying cause lost.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. H. Howard</u> M.D.		22. DATE SIGNED <u>6/21/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JUNE 28-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR <u>FARLEY-CAVANAUGH</u>		25a. REC'D BY REGISTRAR <u>6601 FREDERICK</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 29 1967</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film#G390 6/28/67 pc

07670

CERTIFICATE OF DEATH

07651

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN TB <u>17 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Talbot County</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>605 Dover Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>Ward</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/28/12</u>		9. AGE (In years last birthday) <u>55</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastasis</u> <u>151X</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition; mental deficiency.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/15/</u> , 19 <u>49</u> , to <u>6/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/4/</u> 19 <u>67</u> , and that death occurred at <u>8:10</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>6/5/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict</u>	
22d. ADDRESS <u>Crownsville State Hospital</u>				22e. ADDRESS <u>Crownsville State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>The Anatomy Bld. of Maryland</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR DATE <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07671

CERTIFICATE OF DEATH

07652

1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Chesent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Waring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Nursing Home</u>		d. STREET ADDRESS <u>1142</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>A</u> Middle <u>WARD</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Adelaide Wilkerson</u>		14. MOTHER'S MAIDEN NAME <u>Iva Sterbeck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-34-5504</u>	
17. INFORMANT <u>Wilbur F. Ward, Jr. Sunbury, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u> 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute urinary infection</u> DUE TO (c) <u>Parkinson's Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1965</u> , to <u>June 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 20, 1967</u> ; and that death occurred at <u>11:55 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Emily H. Wilson</u>		22b. DATE SIGNED <u>6/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EMILY H. WILSON</u>		22d. ADDRESS <u>Lothian, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Ch. Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Friendship P. O. Md</u>	
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home, Waring, Md.</u>		25a. REC'D BY REGISTRAR <u>WUN 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07672

CERTIFICATE OF DEATH

07653

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 53 Anne Arundel General Hospital				d. STREET ADDRESS Shadyside			
3. NAME OF DECEASED (Type or print) First Ralph Middle Immich Last WATERS				4. DATE OF DEATH Month June Day 23 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 4, 1907	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 23 Days 19 Hours 67 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME William F. Waters		14. MOTHER'S MAIDEN NAME Edith Turner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 578-18-7782	
16. SOCIAL SECURITY NO. 578-18-7782		17. INFORMANT Mrs. Ollie Waters		Address Deale, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary TB active DUE TO (b) then covered Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 6-22-67 , to 6-23-67 , that (I) (we) last saw the deceased alive on 6-22-67 , and that death occurred at 9:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE A. T. Allen MD				M.D. ATTENDING PHYS. A		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) A T ALLEN MD				22d. ADDRESS 62 G. Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) June 26-1967				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Good Hope	
23d. LOCATION (City or town) (County) (State) Suitland P. Res. Md.				24. FUNERAL DIRECTOR Arthur B. Hall			
25a. REC'D BY REGISTRAR 2546 Carroll St NW				25b. REGISTRAR'S SIGNATURE J. Charles Judge			
DATE JUN 26 1967							

7575

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

1973

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in Maryland (State)

in Maryland (State)

June 11

June 11

June 11

June 11

June 11

June 11, 1973

June 11, 1973

Baltimore City, Maryland

Baltimore City, Maryland

Charles Virginia Trust

Archibald Robertson

Mr. & Mrs. L. Nelson (deceased)

June 11, 1973, Maryland

He

WA

Salisbury, Maryland

June 18, 1973 (American Memorial Park)

Salisbury, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07674

CERTIFICATE OF DEATH

07655

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>Few Hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn 21144</u>			d. STREET ADDRESS <u>Stevenson Road</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Wesley</u> Last <u>Wheeler Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1902</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Operator (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Severn, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William W. Wheeler Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Stella Watts.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Bessie M. Wheeler</u> Address <u>Same as # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6</u> , 19 <u>65</u> to <u>1/5</u> , 19 <u>65</u> , that (I) last saw the deceased alive on <u>4/5</u> 19 <u>65</u> , and that death occurred at <u>11</u> A M, from causes and on the date stated above.							
22a. SIGNATURE <u>Richard I. Hochman, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>				22d. ADDRESS <u>16 Murray Ave, Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem'l Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md.</u>		
24. FUNERAL DIRECTOR <u>R.V. SINGLETON</u>				ADDRESS <u>GLEN BURNIE, MD.</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>

1937

CERTIFICATE OF DEATH

1937

State of New York, County of New York, City of New York, Borough of Manhattan, Precinct of Central Park West.

On the 1st day of January, 1937, at the City of New York, in the County of New York, State of New York, I, the undersigned, a duly qualified and authorized officer of the City and County of New York, do hereby certify that

the within and foregoing is a true and correct copy of the original record of the death of

John Doe, born on the 1st day of January, 1900, at the City of New York, in the County of New York, State of New York, who died on the 1st day of January, 1937, at the City of New York, in the County of New York, State of New York, of the following disease, to-wit:

Heart Disease, and that the same is a true and correct copy of the original record of the death of

John Doe, as the same appears from the original record of the death of

John Doe, as the same appears from the original record of the death of

John Doe, as the same appears from the original record of the death of

John Doe, as the same appears from the original record of the death of

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John Doe, as the same appears from the original record of the death of

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07675

CERTIFICATE OF DEATH

07656

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Aug</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>				c. LENGTH OF STAY IN 1b <u>10-1</u>			
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>310 W. Maple Rd.</u>				d. STREET ADDRESS <u>310 W. Maple Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Sarah E. Whittington</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1967</u>	
8. AGE (In years last birthday) <u>90</u> yrs.		9. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		10. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Howard CO. Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Louis C. Meyer</u>				14. MOTHER'S MAIDEN NAME <u>Louise Krause</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Mrs. Walter E. Albrecht</u>				Address <u>Above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u>							
260X DUE TO <u>Diabetes</u>							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Longrenow Pressure Jones</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1947</u> to <u>6/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> , 19 <u>67</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles L. Ball Jr. M.D.</u>				22d. ADDRESS <u>Linthicum Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>7-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>				25a. REC'D BY REGISTRAR <u>JUL 3 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>							

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STATE OF NEW YORK

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W. W. Jones & Sons Co., New York City, N. Y.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07676

07657

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> 40 yrs. c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 252 - Rt 9 - Old Annapolis Blvd.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Box 252 - Rt 9</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MABEL NM. WILKS</u>		4. DATE OF DEATH Month Day Year <u>JUNE 30 1967</u>		5. SEX <u>FEMALE</u>			
6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 Feb 1901</u>			
9. AGE (In years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Ireland & Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>		13. FATHER'S NAME <u>Thomas Z. Mangum (dec)</u>			
14. MOTHER'S MAIDEN NAME <u>Gertrude Account (dec)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If give, give number and date of service)			
17. INFORMANT <u>Daughter - Mrs Gertrude Macy</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO (b) <u>arteriosclerotic heart disease</u> (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>approx. 1963</u> to <u>present</u> , 19____, that (I) (we) last saw the deceased alive on <u>23 June 1967</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>H. F. Manuzak</u>		22b. DATE SIGNED <u>30 June 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>H. F. MANUZAK</u>			
22d. ADDRESS <u>425 S. RITCHIE HWY, Glen Burnie, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>7/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) _____ (State) _____ <u>Balto. Co. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</u>		25a. REC'D BY REGISTRAR <u>JUL 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Johnnie Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 07677											
1. PLACE OF DEATH a. COUNTY <i>A. A. Co.</i> b. CITY OR TOWN (if outside corporate limits, write <i>RURAL</i> and give nearest town) <i>Severna Park</i> c. LENGTH OF STAY IN 1b <i>1 Day</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A. A. Co.</i> c. CITY OR TOWN (if outside corporate limits, write <i>RURAL</i> and give nearest town) <i>Severna Park</i> d. STREET ADDRESS <i>Labeland on the Severna</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Katherine R. Wogner</i>			4. DATE OF DEATH Month <i>6</i> Day <i>19</i> Year <i>67</i>			5. SEX <i>F</i>			6. COLOR OR RACE <i>W</i>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>3-4-84</i>			9. AGE (In years last birthday) <i>83</i> yrs.			10. IF UNDER 1 YEAR: Months <i>12</i> Days <i>12</i> Hours <i>19</i> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Hermon Thomas</i>			14. MOTHER'S MAIDEN NAME <i>Amelia Dittmer</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT <i>Wm. Keith Kettinger</i>			Address <i>Above</i>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a); <i>uremia</i> <i>443X</i> DUE TO (b); <i>H.C.V.D.</i> DUE TO (c); <i>Gen. est.</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>June 19 67</i>			20f. (City or town) (County) (State) <i>June 19 67</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>1967</i> , 19 <i>1967</i> , 19 <i>1967</i> , that (I) (we) last saw the deceased alive on <i>6-19-67</i> , 19 <i>1967</i> , and that death occurred at <i>5P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Robert R. Hahn</i> M.D.						22b. DATE SIGNED <i>June 19 67</i>			22c. PHYSICIAN'S NAME (Type) <i>ROBERT R. HAHN</i>		
22d. ADDRESS <i>SEVERNA PARK, Md.</i>						22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>6-23-67</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Green Haven</i>			23d. LOCATION (City, town or county) (State) <i>Green Haven A. A. Md.</i>		
24. FUNERAL DIRECTOR <i>Robert S. Barranco</i>						24a. ADDRESS <i>Severna Park, Md.</i>			24b. REC'D BY REGISTRAR <i>June 26 1967</i>		
24c. SIGNATURE <i>Charles Judge</i>						24d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			24e. ADDRESS		

CERTIFICATE OF DEATH

1917

A. A. Co.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07678

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07659

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn c. LENGTH OF STAY IN ID 1 yr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box - 41 Rt. # 2				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn d. STREET ADDRESS Box - 41 Rt. # 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SUSIE Middle BRAOY Last WOOD				4. DATE OF DEATH Month June Day 15 Year 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 Dec. 1873	
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 02 Days 1 Hours 00 Min. 00		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Samuel Brady				14. MOTHER'S MAIDEN NAME Maggie Ketton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 228-70-0925-01		17. INFORMANT Mrs. William H. Grape (Daughter)		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiovascular disease 4500 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Emler G. Linhardt EXAMINER'S NAME (Type)				22. DATE SIGNED 6-15-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 19 June 67		23c. NAME OF CEMETERY OR CREMATORY Free Union Cemetery		23d. LOCATION (City, town or county) (State) Free Union, Virginia	
24. FUNERAL DIRECTOR Robert R. Ware Address Singleton Funeral Home/ Glen Burnie, Md.				25a. REC'D BY REGISTRAR JUN 16 1967 OATE 25b. REGISTRAR'S SIGNATURE James Judge			

THE STATE
OF VIRGINIA

1977

WILLIAM STANLEY, JR., DECEASED
BY AND UNDER THE WILL OF
WILLIAM STANLEY, JR., DECEASED

IN SENATE

January

1977

Session

1-27

Box - 41 11

Box - 41 11

June 12 1977

June 12 1977

10 Dec 1977

10 Dec 1977

U.S.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07673

CERTIFICATE OF DEATH

07660

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL- GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-PASADENA</u>	
c. LENGTH OF STAY IN 1b <u>1 DAY</u>		d. STREET ADDRESS <u>3 RITCHIE HWY.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>EUGENE</u> Last <u>ZAHN</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1, 1872</u>
9. AGE (In years lost birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Josephine Howard</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Zahn</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Helen Ireland, 3 Ritchie Highway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-1486</u>	
17. INFORMANT <u>Mrs. Helen Ireland, 3 Ritchie Highway</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease -</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sclerosis Cerebri Vascular Hemorrhage</u> DUE TO (c) <u>Pneumonia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-5</u> , 19 <u>67</u> to <u>6/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> , 19 <u>67</u> and that death occurred at <u>2:40</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John F. Feltz</u>		22b. DATE SIGNED <u>6/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Feltz, John F.</u>		22d. ADDRESS <u>11130 Owens Rd. Odenton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Benjamin's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Westminster, Carroll, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pasadena & Md.</u>		25. REG'D BY REGISTRAR <u>JUN 14 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		27. REGISTRAR'S SIGNATURE	

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UNITED STATES OF AMERICA

07350

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UNITED STATES OF AMERICA